

MONTANA ACTION PLAN

and

Conference Proceedings

of the

1986 GOVERNOR'S CONFERENCE ON
HEALTH PROMOTION & DISEASE PREVENTION

PLEASE RETURN

STATE DOCUMENTS COLLECTION

JUN 3 1987

MONTANA STATE LIBRARY,
1515 E. 6th AVE.
HELENA, MONTANA 59620



Sponsored by

Montana Statewide Health Coordinating Council
Montana Department of Health & Environmental Sciences

MONTANA STATE LIBRARY

S 613.043 H2map 1986 c.1

Montana action plan and conference proce



3 0864 00055305 0

due JAN 6 1988
JUL 1 2 1990

CONTENTS

Page

Section I

Department Policy Statement	i
Abstract	ii
Preface	iii
Introduction and General Issues	1
Preconception	3
Prenatal	5
Labor and Delivery/Newborn	7
Preschool	11

Section II

Health Objectives, as amended	13
Preconception	14
Prenatal	26
Labor and Delivery/Newborn	37
Preschool	46

Section III

Welcome Address Governor Ted Schwinden	56
National 1990 Objectives James Harrell	59
Keynote Address C. Arden Miller, M.D.	64
Accessing the Media Kyla Thompson	79
Multi-dimensional Approach to Health Robert Lind	91

Handwritten:
9/10/84
20/82

DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES



TED SCHWINDEN, GOVERNOR

COGSWELL BUILDING

STATE OF MONTANA

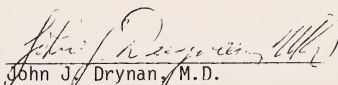
HELENA, MONTANA 59620

May 12, 1986

DEPARTMENT POLICY STATEMENT

The conference report of the 1986 Governor's Conference on Health Promotion and Disease Prevention comprises an extensive action plan to improve the health status of Montana's perinatal and preschool population. The report, developed through a consensus planning process involving Montana's primary care and service providers, can serve as a guide in determining the direction of public health regarding preconceptual counseling, prenatal care, preterm labor and preterm delivery prevention, newborn care, and preschool health.

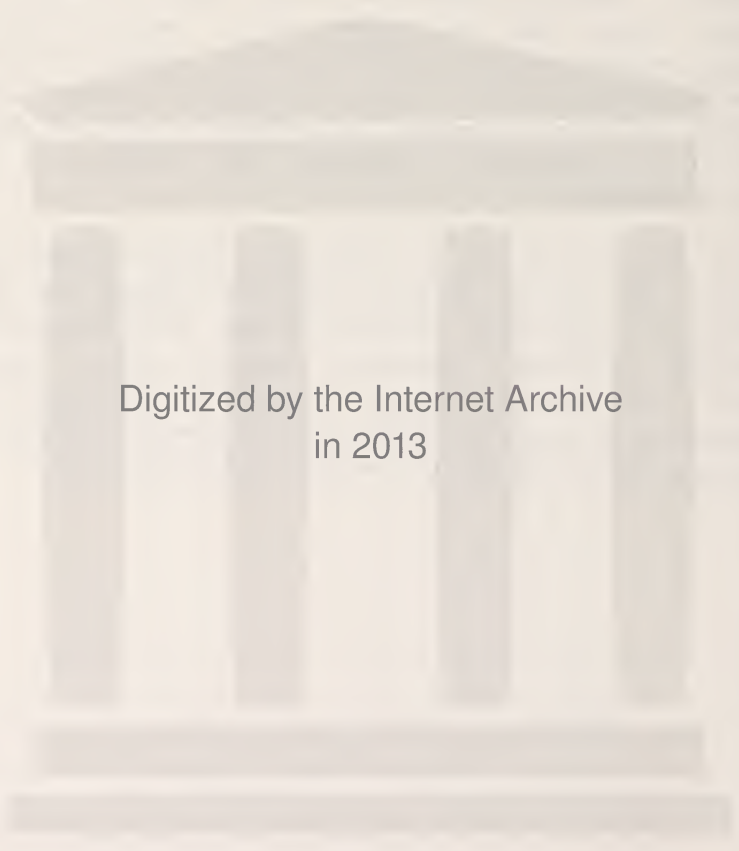
As Director of the Montana Department of Health and Environmental Sciences, I endorse--as a policy guide--the conference report of the 1986 Governor's Conference on Health Promotion and Disease Prevention. Accordingly, this report will help formulate public policy decisions on current and future health care issues concerning perinatal and preschool health and the interrelated issues of maternal health.


John J. Drynan, M.D.
Director
Montana Department of Health
and Environmental Sciences

ABSTRACT

The 1986 Governor's Conference on Health Promotion and Disease Prevention considered issues surrounding perinatal and preschool health -- issues on preconceptual counseling, prenatal care, preterm labor and preterm delivery prevention, newborn care, and preschool health. Several priorities were developed through the consensus planning process that involved the primary care and service providers for the 0 - 5 years of age group. The priorities were (a) appropriate and effective education, (b) statistically valid and significant data, and (c) coordination of education, data collection, and resource allocation activities.

Education could be addressed via a kindergarten through 12 health education curriculum. Data could be improved by implementing improved birth and death certificates, by establishing a high-risk registry, and by increasing general epidemiology surveillance. Coordination activities could be accomplished through a task force or coalition comprised of broad-based community representatives and primary care providers with an interest in improving overall health status and with the ability to evaluate resource allocations.



Digitized by the Internet Archive
in 2013

<http://archive.org/details/montanaactionpla1986gove>

PREFACE

The Montana Statewide Health Coordinating Council (SHCC) and the Montana Department of Health and Environmental Sciences (DHES) sponsored an invitational conference in February, 1986, for the primary health and service providers for Montana's perinatal and preschool population. This conference -- the 1986 Governor's Conference on Health Promotion and Disease Prevention -- deliberated health promotion and disease prevention strategies needed to implement health improvements among Montana's young children, unborn and born. Concurrently, maternal health and lifestyle behaviors were given significant attention due to the obvious relationship between mothers and babies.

The conference was held:

- (1) to provide a forum for informational exchange among primary care providers who serve Montana's perinatal and preschool populations,
- (2) to develop health promotion and disease prevention strategies to implement health improvements among Montana's perinatal and preschool populations,
- (3) to identify the resources available in Montana for perinatal and preschool populations, and
- (4) to evaluate the impact health promotion and disease prevention activities will have on Montana's perinatal and preschool populations.

The SHCC and the DHES acknowledge the efforts of the conference participants in helping to create this policy document for the resource and service decisions related to perinatal and preschool health in Montana. The participants were:

Ellen Leahy
Missoula City-County Health Dept.
301 West Alder
Missoula, MT 59802

Thomas Robertson, Administrator
Dawson County Health Dept.
207 West Bell
P. O. Box 811
Glendive, MT 59330

Senator Pat Regan
Montana Senate
204 Mountain View
Billings, MT 59101

Dolly Browder
1735 Gerald
Missoula, MT 59801

Cindy Brown, R.D., M.S.
St. Peter's Community Hospital
2475 Broadway
Helena, MT 59601

Kathy Manion, R.N.
School District #9
P. O. Box "H"
East Helena, MT 59635

Marcus A. Johnson, M.D.
P. O. Box 160
Choteau, MT 59422

Don G. Marshall, DDS
1240 Dewey Blvd.
Butte, MT 59701

Stephanie Nelson, R.N.
c/o Gallatin Co. Health Dept.
Courthouse, Room 103
Bozeman, MT 59715

Polly Junkermier Poole, R.D., M.S.
Director of Dietetics & Food
Service
Montana Deaconess Medical Center
1101 26th Street
Great Falls, MT 59405

Marietta Cross, R.N.
Missoula Community Hospital
2827 Fort Missoula Road
Missoula, MT 59801

Stanley Rosenberg
4720 Itana Circle
Bozeman, MT 59715

Lillie Anderson, R.N.
Chief of Human Services
Yellowstone City-County Health Dept.
Courthouse, Room 308
P. O. Box 35033
Billings, MT 59107

Arleen Cannon, R.N.
Child Birth Education
3550 Stucky Road
Bozeman, MT 59715

Jan Donaldson, R.N.
Pediatric Neurology Services
840 Helena Avenue
Helena, MT 59604

James Feist, M.D.
7 East Beall
Bozeman, MT 59715

Joan Fitzgerald
Shodair Children's Hospital
840 Helena Avenue
P. O. Box 5539
Helena, MT 59604

Kristin Fox
March of Dimes, National Foundation
Stapelton Building
P. O. Box 457
Billings, MT 59103

Rita Harding, R.N.
CHN Officer
Indian Health Service
711 Central Avenue
P. O. Box 1243
Billings, MT 59103

Elaine Fordyce, R.N.
Toole County Health Dept.
Courthouse
Shelby, MT 59474

Pam Harris, R.D., M.S.
16430 Brackett Creek Road
Bozeman, MT 59715

Patricia Huber
EPSDT, Dept. of Social and
Rehabilitation Services
SRS Building
111 Sanders
Helena, MT 59620

Connie Kalberg
Western Montana Comprehensive
Development Center
T-124 Fort Missoula Road
Missoula, MT 59801

Peter L. Burleigh, M.D.
P. O. Box 5012
Great Falls, MT 59403

Kathi Campbell
1610 Flowerree
Helena, MT 59601

Paul Miller
Medicaid Services Bureau
Department of Social and
Rehabilitation Services
Room 103, SRS Building
111 Sanders
Helena, MT 59620

Peggy Mussehl
1410 Cherry Drive
Bozeman, MT 59715

Andrea Pagenkopf, R.D., P.L.D.
Food and Nutrition Specialist
Cooperative Extension Service
Montana State University
Bozeman, MT 59717

William H. Deschner, M.D.
Billings Clinic
P. O. Box 35100
Billings, MT 59107

Cheryl Olson-McMillan, R.N.
Montana State University
College of Nursing
Missoula Extended Campus
612 Eddy
Missoula, MT 59812

John Alden, CNM
Indian Health Service
P. O. Box 67
Poplar, MT 59255

Dorothy Porter, R.D., M.P.H.
Nutrition & Dietetics Consultant
Indian Health Service
P. O. Box 2143
Billings, MT 59103

William J. Peters, M.D.
300 North Willson, #2004
Bozeman, MT 59715

Albert E. Goke, Administrator
Highway Traffic Safety Division
Department of Justice
303 North Roberts
Helena, MT 59620

Kyle Hopstad, Administrator
Frances Mahon Deaconess Hospital
621 Third Street South
Glasgow, MT 59230

Mary Taylor, R.N.
Nursing Director
Missoula City-County Health Dept.
301 West Alder Street
Missoula, MT 59802

Dean Effler
Indian Health Service
Billings Area Office
2727 Central Avenue
Billings, MT 59103

Sue Fifield
Box 232
Clinton, MT 59825

Daniel A. Harper, M.D.
2825 Fort Missoula Road
Missoula, MT 59801

Sharon Hovey, M.N., R.N.C.
4026 6th Avenue South
Great Falls, MT 59405

Doris Olson, M.S.W.
St. Vincent Hospital
Social Services Department
1233 North 30th Street
P. O. Box 35200
Billings, MT 59107-5200

Terry Screnar
Blue Cross of Montana
P. O. Box 5004
Great Falls, MT 59403

Alan Cain
Blue Shield -- Home Office
404 Fuller Avenue
Helena, MT 59601

Cheryl Fowler
State Auditor and Ex Officio
Commissioner of Insurance
State Auditor's Office
Room 270, Mitchell Building
Helena, MT 59620

Doris Biersdorf, R.D.
721 North 29th Street
Billings, MT 59101

Introduction

The Governor's Conference on Health Promotion and Disease Prevention generated sincere deliberation on many issues regarding perinatal and preschool health. These issues included preconceptual counseling, prenatal care, pre-term labor and pre-term delivery prevention, newborn care, and preschool health.

The discussions were initiated through a series of Montana-based health objectives encompassing preventive health services, health protection, and health promotion. The selected objectives focused on perinatal and preschool health and were taken from Healthy Montanans: 1990 Perspectives. Specifically, the objectives considered the health-impacting topics of family planning, pregnancy and infant health, immunization, sexually transmitted diseases, toxic agent control, accident prevention and injury control, oral health, infectious diseases, nutrition, and stress and violent behavior.

General Issues

Several priorities surfaced in each of the conference work groups. These priorities were made evident during the deliberations of each group and by the actions the group designated as necessary to accomplish the health objectives. The priorities are:

- appropriate and effective education
- statistically valid and significant data

- coordination of activities involving education, data collection, and resource allocation.

The work groups suggested some possible means to address these three priorities. First, for education, a kindergarten through grade 12 (K-12) health education curriculum should be universally instituted. An emphasis should be placed on self-responsibility for health education, especially for persons not in the K-12 group. Parenting education should be improved and increased. Lobbying and education of Montana's legislative members and the executive branch must be undertaken in order that they can fully comprehend the economic importance of improvements in maternal and infant health.

Second, the data base from which the evaluation of program/service effectiveness is derived is inadequate. The birth certificates and death certificates should be improved to increase both the quantity and quality of information. A state-wide high-risk registry should be established to collect data and disseminate information to primary care providers based on the data. The need for general epidemiology surveillance and focused studies was recognized repeatedly throughout the conference.

Third, each of the groups suggested a similar manner in which to coordinate the activities surrounding perinatal and preschool education, data and resources. Essentially, a group (referred to in the different work groups as a task force, a coalition, a liaison group, and as a network) should be formed for continued study of perinatal and preschool health issues, for review and recommendation activities on education, data and resources, for assessing the progress made in achieving the selected health objectives, and for continuing the dialogue among

the primary care providers and other representatives assembled at the conference.

Since the financial resources for an independent group are not likely to be available, it was suggested that these activities could be superimposed with the efforts of the existing coalitions such as Montana's Healthy Mothers/Healthy Babies Coalition or the Montana Perinatal Program Advisory Committee. Two related ideas are to involve Department of Health programmatic support, and to include in the group constituency an attorney with experience in health care issues.

Preconception

The priorities of this group were education in family planning, preconceptual information (including material on nutrition, weight control, smoking, alcohol and other drugs), and improved data in all areas impacting perinatal health (ranging from fetal alcohol syndrome to toxic agents to infectious diseases).

The primary way to address the preconception group priorities involves a K-12 curriculum for sex/health education, possibly enacted by a mandatory education requirement. An organized data collection system should be set up to evaluate the scope of the problems and to evaluate the impact any actions may have in altering negative health trends.

Some points of interest discussed by the preconception group include:

- The ability to decide on and correctly use contraceptive methods is more important to achieving the health objective than simply the knowledge and ability to describe those methods.
- Beyond the classroom, education should be provided for the general public to correct any misinformation. The education should also be used to heighten provider information.
- Lack of significant, valid and current data were perceived as a major prohibitive factor in the process.
- A broader awareness should be made of the value of genetic counseling in preconceptual planning.
- The effect of acquired immune deficiency syndrome (AIDS) should receive attention in family planning and counseling.
- Emphasis is needed on the public health implications of the health status of foreign students and foreign adoptees.
- A task force should be formed to give direction to the activities associated with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE). Fetal Tobacco Syndrome, recently addressed in literature, should also be given consideration.

Prenatal

The priority of this group was early and comprehensive prenatal care for everyone. Basic to this priority were the considerations of funding of prenatal care and numbers of prenatal visits as a gauge to attaining quality and comprehensive prenatal care. The major barriers to early and comprehensive prenatal care are:

- financial constraints such as inadequate insurance or lack of Medicaid funds to purchase care;
- limited availability of maternity care providers, particularly providers willing to serve socially disadvantaged or high-risk pregnant women;
- insufficient prenatal services in some sites routinely used by high-risk populations, such as community health centers, hospital outpatient clinics, and health departments;
- experiences, attitudes, and beliefs among women that make them disinclined to seek prenatal care;
- poor or absent transportation and child care services; and
- inadequate systems to recruit hard-to-reach women into care.

The methods this group suggested to address the priority need included improved data, education (of health care providers, legislators, third party payers, lay public and consumers of the service), locating funding sources, and forming local level groups with broad-based community representation to serve as the main focal point for facilitating prenatal care activities.

Some points of interest discussed by the prenatal group include:

- The group consensus of an overall health objective to which other objectives become supporting steps. The objective is included in the appendix as the first objective in the prenatal section.
- Sexually transmitted diseases are a lower priority in prenatal care, although complete data are not available on the involvement of certain STD's as a cause of premature labor.
- The denial of pregnancy precludes seeking early and comprehensive prenatal care.
- Consideration was given to the issue of malpractice insurance coverage to keep professional health care providers actively engaged in prenatal care.
- Wellness programs should be given a strong consideration in insurance coverages and premiums.

- An incentive program concept involved registering pregnant women and the physicians involved in preterm labor prevention projects. Registered persons could receive some lowered health insurance or malpractice insurance premium as a benefit of participating in a project to contain the high costs associated with preterm labor and preterm delivery of low birthweight babies.
- A legislative mandate to require insurance coverage for pregnant women who must leave their jobs was discussed. Also, legislation was mentioned that would ensure maternity leave allowances and job-return guarantees so women will have more freedom to seek early prenatal care when it is needed.
- The data for considering prenatal issues could be improved by improving the birth certificates. The requirement for more information on the birth certificate could include maternal smoking, environmental influences, and factors complicating pregnancy (such as anemia, etc.).
- The interaction of primary care providers and others concerned with prenatal care with the Montana Perinatal Program Advisory Committee was seen as a logical step.

Labor and Delivery/Newborn

The priorities of this group centered on services, education, valid data, and a coalition. The priorities were (1) early prenatal care by qualified providers

is essential, should be guaranteed to all Montana women, and can be viewed as an obligation to protect the soon-to-be-born; (2) through educational efforts increase the number of women seeking early prenatal care and increase their awareness of positive lifestyle behaviors and attitudes; and (3) that a coalition of legislators and broad-based maternal and infant health representatives review and recommend priorities for MCH activities and resource allocation.

The primary ways this group suggested to address the priorities were education regarding the cost-effectiveness of maternal and infant health dollars, including the availability of community health nurses in each county trained to provide MCH services to high-risk groups; a statistically valid and organized data collection system to identify high-risk groups and to help evaluate the impact of services; and to form a statewide coalition to provide recommendations on education, data collection, and resource allocations.

Some points of interest discussed by the labor and delivery/newborn group were:

- The Caucasian and Native American populations should have the same health objectives.
- The education and support of healthy lifestyles and the issues of teen pregnancy are essential.

- The education of legislators (possibly through a legislative interim study) on the dollars the state expends for high-risk/complicated pregnancies, deliveries and newborns is essential.
- Continued support for the transport of high-risk pregnant women and high-risk newborns is essential.
- The activities necessary to bring about health improvements must be ranked in order of importance, and allocation of resources must be done accordingly. As a first step, however, the problems need to be ranked before the subsequent activities can be decided upon.
- Financial incentives for lifestyle changes include lower insurance rates or the actual reimbursement of a set number of dollars for each person who makes positive changes in their lifestyle and maintains that positive lifestyle. This idea involves a formal contract between the employer/insurer and the insured employee.
- The lack of valid data is evident. An improved birth certificate and a properly organized high-risk registry could be used to help determine the causes of low birthweight. Among other data, a comparison of high-risk assessments done at the first prenatal visit and at 24-28 weeks of pregnancy would be useful in studying premature labor. These assessments could also be used to identify individuals at high risk for preterm labor.

- The midwifery issue was seriously deliberated. The discussion ranged from restricting lay midwifery and discouraging home births, to increasing the number of nurse midwives providing services in a rural state like Montana, to malpractice considerations in OB care primarily among physician providers. Essentially the group expressed a need for minimum standards to define the level of expertise that should be available to all Montana's child-bearing women, regardless of the type of practitioner present at the delivery.

- Cost-containment measures have led to birthing rooms and quick discharge after delivery. With financial pressures causing debate over hospital closures, accessibility to care may become even more disproportionate in Montana. The impact of these issues must be understood.

- The reality was obvious that maternal and infant health programs will be facing staggering expenditure reductions at both the national and state levels with a corresponding negative effect on effective and proven interventions.

- Education about positive lifestyles and lifestyle risks before and during pregnancy is an important factor. This education, combined with early and comprehensive prenatal care, formed the primary focal point of the group discussions.

Preschool

The priorities of this group were perceived to be effectively targeted education, improved data and monitoring, and a networking group for continued dialogue and information referral.

The ways the preschool group mentioned to address the priorities included knowing what currently exists and how to make use of it; targeting education (school curricula, professional providers, general public) to whom you want to educate and doing that in the most appropriate manner; compiling useful and valid data to know where to target limited resources for the greatest impact on health improvement; and setting up a network of the various disciplines who work with preschool kids so that continuous input and feedback is provided on the problems, progress and solutions on health issues affecting preschoolers.

Some points of interest discussed by the preschool group were:

- The biggest need is for valid data to help target resources. The focus of a valid data base is to identify, prevent, and educate the high-risk populations. Prevention and education cannot begin until the current status of the problem is identified and substantiated.
- A state law mandating fluoridation of municipal water supplies for cities over a certain population was suggested. It was noted that fluoride use is the leading preventive measure against dental caries; it is also the most cost effective.

- In considering the financial responsibility of fluoride treatment (both municipal and individual), it was suggested that those receiving the direct benefit pay for the service. This was not seen as a responsibility of the State.
- Dental health should be a part of the health curriculum in schools. Adult education should also be presented, including in those communities without fluoridated water supplies.
- Unregistered day care providers do not usually have access to nor do they normally provide good nutritional information and care.
- In child abuse and stress, addressing mental health is the primary objective. Activity in Montana seems too fragmented and piecemeal; consequently, no overall program or system exists in Montana to reduce violence in the home.
- Family planning was suggested as a possible solution to some of the child abuse problems. This was based on the idea that some child abuse occurs because many children are simply not wanted.
- Emotional health of a family unit has an impact on stress, violent behavior, and child abuse. Resource and referral services to assist the dysfunctional family should be a priority in Montana.

APPENDIX

Objective: By 1990, reduce unintended pregnancies among Montana women 15-44 by 50% of the present rate.

Who is responsible:

Family planning programs, public health agencies, schools, churches, families, private physicians.

Resources needed:

Additional funds to expand family planning services and community education outreach efforts. Funds will also be needed to work with the Office of Public Instruction (OPI) and other agencies in educating the public on reproduction health and contraception.

Data are needed to measure this objective.

Steps to achieve the 1990 Objective:

1. Expand the availability and accessibility of family planning services in Montana by increasing the number of family planning clinics in the state. This could only be done contingent upon significantly increased funding for family planning in the state.
2. Family planning personnel to meet with staff of OPI to gain their support and commitment to implement a reproductive health and contraceptive education program or a family life curriculum in Montana schools. A mandatory education requirement might be necessary.
3. Family planning personnel would assist OPI in their efforts to implement the program.
4. Expand family planning's community education efforts regarding reproductive health and contraceptives in order to reach men and women not enrolled in public schools to include: a) church groups; b) civic groups; c) the media; d) physicians' offices; e) public health departments.

Comment:

If the message is portrayed to teenage girls that marriage and motherhood are their lifetime goals (especially if they are marginal students), those girls may perceive it as acceptable behavior to achieve that goal while still in high school.

A statewide K-12 curriculum should be developed and instituted to provide age-appropriate continuing education for responsible reproductive decision-making.

Objective: By 1990, increase family planning information and services to Montana men and women of all economic levels.

Who is responsible:

Family planning programs, public health agencies, schools, churches, families, private physicians, statewide genetic services program.

Resources needed:

Additional funds to expand family planning services and community education outreach efforts. The goal of family planning services is to assure all couples have access to services to enable them to voluntarily control their fertility rate regardless of income. Priority is given to low-income women. Funds will also be needed for additional staff to work with the Office of Public Instruction (OPI) and other agencies in educating the public on reproduction health contraception and the availability of subsidized family planning services.

Data are needed to measure this objective.

Steps to achieve the 1990 Objective:

1. Expand the availability and accessibility of subsidized family planning services in Montana by increasing the number of family planning clinics in the state. Publicize existing programs more, especially in outlying areas.
2. Family planning personnel to meet with staff of OPI to gain their support and commitment to implement a reproductive health and contraceptive education program in Montana schools. A mandatory education requirement might be necessary.
3. Family planning personnel would assist OPI in their efforts to implement the program.
4. Expand family planning's community education efforts regarding reproductive health and contraceptives in order to reach men and women not enrolled in public schools to include: a) church groups; b) civic groups; c) the media; d) physicians' offices; e) public health departments.
5. Change current legislation with regard to dispensing of contraceptives to minors and patient confidentiality.
6. Provide adult education on teen sexuality to decrease the teen's fear of discovery.
7. Incorporate medical genetics personnel into health education endeavors.

Objective: By 1990, at least 75 percent of Montana men and women over the age of 14 should be able to describe accurately the various contraceptive methods, including the relative safety and effectiveness of one method versus the others.

Who is responsible:

Family planning programs, public health agencies, schools, churches, families, private physicians.

Resources needed:

Additional funds to expand family planning's community outreach efforts and to work with OPI and schools in implementing reproductive health education programs including contraceptive education for all students.

Steps to achieve the 1990 Objective:

1. Family planning personnel to meet with staff of OPI to gain their support and commitment to implement a contraceptive education program in Montana schools. A mandatory education requirement might be necessary.
2. Family planning personnel would assist OPI in their efforts to implement the program.
3. Expand family planning's community education efforts regarding contraceptives, in order to reach men and women not enrolled in public schools to include: a) church groups; b) civic groups; c) the media; d) physicians' offices; 3) public health departments.
4. Family planning legislation should be developed separately from legislation on issues dealing with abortion.

Comments: The Montana Statewide Family Planning Program does not have the resources to launch a statewide contraceptive education program. It can only assure that clients enrolled in Title X Family Planning Programs can accurately describe the various contraceptive methods.

Emphasis should be given to the shared responsibility of contraception practices for both males and females. Decision on and use of contraception is more important than the ability to describe various methods.

Objective: By 1990, there should be no unintended pregnancies to girls 14 years old or younger in Montana.

Who is responsible:

Family planning programs, public health agencies, schools, churches, families, private physicians, Office of Public Instruction, Montana Education Association.

Resources needed:

Additional funds to expand family planning services and community education outreach efforts. Funds will also be needed to work with Office of Public Instruction (OPI) and other agencies in educating this age group on reproductive health, contraception and the availability of subsidized, confidential family planning services.

Steps to achieve the 1990 Objective:

1. Expand the availability and accessibility of subsidized family planning services in Montana by increasing the number of family planning clinics in the state. This could only be done with significantly increased funding for family planning in the state.
2. Family planning personnel to meet with staff of OPI to gain their support and commitment to implement a reproductive health and contraceptive education program in Montana schools to impact this age group. A mandatory education requirement might be necessary.
3. Family planning personnel would assist OPI in their efforts to implement the program.
4. Expand family planning's community education efforts regarding reproductive health and contraception in order to reach men and women not enrolled in public schools to include: a) church groups; b) civic groups; c) the media; d) physician's offices; e) public health departments.
5. Promote positive self-concept through family and youth organizations and schools. Develop a method to include high risk children who do not have contact with or access to family and youth organizations.
6. Increase contraception education to males to improve the sense of shared responsibility.

Objective: By 1990, the incidence in Montana of infants born with Fetal Alcohol Syndrome should be reduced by 25 percent.

Who is responsible:

Local public health agencies, schools, churches, parents, health care providers, family planning programs, individuals, Montana Perinatal Program, Handicapped Children's Services.

Resources needed:

Baseline data.

Funds to promote education through the school curriculum regarding substance abuse during pregnancy.

Establish an accurate reporting mechanism.

Steps to accomplish the 1990 Objective:

1. Establish accurate baseline data on the incidence of fetal alcohol syndrome.
2. Provide education to the high risk population.
3. Determine the level of public-at-large and high risk group understanding of the problem.
4. Encourage responsibility in the individual for their own healthy lifestyle.
5. Develop public advertising similar to that being done about the risks associated with smoking and pregnancy. Include this concept in the school health curriculum to provide information prior to the child bearing years.

Objective: By 1990, 95 percent of Montana's women of childbearing age should be able to choose foods wisely and understand the hazards of smoking, alcohol, pharmaceutical products and other drugs during pregnancy and lactation.

Who is responsible:

Public and private health care providers, private nutritionists, tobacco industry, alcohol industry, drug companies, state and local health departments, schools -- health curricula.

Resources needed:

Baseline data.

Federal.

State.

Private.

Steps to achieve the 1990 Objective:

1. Mandated health education in kindergarten through the 12th grade, including nutrition and effects of substance abuse including smoking and alcohol during pregnancy.
2. Public relations through all forms of the media.
3. University curriculum changes to enhance health education and nutrition education for teachers.
4. Medical school curriculum changes.
5. Media changes (soap, all TV programming).
6. Increase the awareness of a risk phone line.
7. Include extension services, church groups, and wellness groups in the education phase. Place educational information in shopping malls and at health fairs.

Objective: By 1990, the incidence of neural tube defects in Montana should be reduced to 1.0 per 1,000 live births.

Who is responsible:

Public health agencies, private health providers and individuals.

Resources needed:

Public and private funding.

Steps to achieve the 1990 Objective:

1. Develop an accurate data base.
2. Public and professional education.

Objective: By 1987, at least 95 percent of health care providers seeing suspected cases of sexually transmitted diseases should be capable of diagnosing and treating all currently recognized sexually transmitted disease (STD).

Who is responsible:

Health care providers (physicians, public health nurses, etc.), STD Program.

Resources needed:

(e.g. inservice training (workshops to refine STD skills of health providers)).

Funds for educating/informing providers.

Funds for treating the STD.

Steps to achieve the 1990 Objective:

1. Survey STD delivery services to identify and correct deficiencies.
2. Develop standardized and improved data collection systems.
3. Complete the development of Quality Assurance Guidelines for STD clinical care and distribute to all appropriate health providers.
4. Distribute current STD information as it becomes available so health providers are operating with state-of-the-art information.

Objective: By 1990, at least 70 percent of Montana's primary care physicians should be able to identify the principal health consequences of exposure to each of the major categories of environmental threats to health.

Who is responsible:

Montana Medical Association
American Medical Association
CDC
Individual Physicians
Montana Chapter of the American College of Obstetrics and Gynecology
Montana Chapter of the American Academy of Family Physicians
Montana Chapter of the American Academy of Pediatrics

Resources needed:

Funding to establish and maintain central data source to be used by physician.

Funding to provide access to terminals to all user physicians.

Steps to achieve the 1990 Objective:

1. Identify existing data sources, i.e., CDC, National Cancer Institute, National Institute of Health.
2. Designate one national organization to complete data and design computer program to give access to user physicians.
3. Provide information to all physicians so they could enter all available patient data and symptoms and get back possible diagnosis.
4. Promote and use a telephone risk line.
5. Identify toxic agents of importance in Montana and focus attention on these areas.
6. Investigate private sources of funding for toxic agent control education and risk line. Private sources may include those industries involved in or facing future involvement in litigation resulting from toxic agent problems.

Objective: By 1990, surveillance and control systems in Montana should be capable of responding to and containing: 1) newly recognized diseases and unexpected epidemics of public health significance; and 2) infections introduced from foreign countries.

Who is responsible:

Department of Health, local health officers and their representatives and all health providers.

Resources needed:

Funds for epidemiologic study/oversight of new diseases and of surveillance/control of all diseases (e.g., computerization of data management system; comprehensive epidemiologic aid to local health agencies).

Steps to achieve the 1990 Objective:

1. 1987 State General Funding for surveillance and control systems similar to other states. (We have statutes and rules for communicable disease control now. We don't have the funds to do what's ideal, done in other states, or even what is minimally acceptable.)
2. Doctorally-prepared epidemiologist and support staff.

Comment: An awareness of the health status of foreign students and foreign adoptees is needed. These groups should have the same requirements on disease reporting and immunizations as the native population, and, in fact, do have the same requirement.

Objective: By 1990, at least 90% of Montana women should be aware of the special health risks for women who smoke, including the effect on outcomes of pregnancy and the excess risk of cardiovascular disease with oral contraceptive use.

Who is responsible:

Voluntary health agencies, family planning, tobacco industry, legislative branch, obstetricians, private physicians, Healthy Mothers/Healthy Babies Coalition, hospitals, local and state health departments.

Resources needed:

Baseline data.

Steps to achieve the 1990 Objective:

1. Determine costs and benefits of smoking during pregnancy.
2. Participate in the Montana Healthy Babies, Healthy Mothers Coalition designed to improve the quality of education for the pregnant women.
3. Support professional training and guidance materials for high risk mothers.
4. Support local surveys of existing knowledge levels, how the high risk populations receive their information on health and health care.
5. Support model educational programs that deal with smoking and the effects on pregnancy.
6. Serve as a public resource of information to individuals, institutions, and organizations in Montana.

Comment: Many of the same activities listed under Pregnancy and Infant Health Objective 7 apply here as well.

Objective: By 1990, the incidence of infants born with Fetal Alcohol Syndrome should be reduced by 25 percent.

Objective: By 1990, the proportion of women of childbearing age aware of risks associated with pregnancy and drinking, in particular, the Fetal Alcohol Syndrome, should be greater than 90 percent.

Objective: By 1990, a comprehensive data capability should be established to monitor and evaluate the status and impact of misuse of alcohol and drugs on: health status; motor vehicle accidents; accidental injuries in addition to those from motor vehicles; interpersonal aggression and violence; sexual assault; vandalism and property damage; pregnancy outcome; and emotional and physical development of infants and children.

Who is responsible:

All health services providing prenatal care (physicians, nurses, midwives, alcohol and drug programs, family planning programs, school health classes, state and local health departments.

Resources needed:

Baseline data.

Printed material available from Alcohol and Drug Abuse Division.

Films available on loan from the Health Department Film Library.

Increased efforts in this health area by Indian Health Service.

Trained speakers.

Continued funding at or above current levels for health services pertaining to pregnancies.

Steps to achieve the 1990 Objective:

1. Requests from applicable source for films and printed material.
2. Contact local Indian Health Service Office in Billings.
3. Encouraging increased Fetal Alcohol Syndrome (F.A.S.) awareness campaigns. Define and differentiate between Fetal Alcohol Syndrome and Fetal Alcohol Effect.
4. Compile a list of available speakers to provide education at cost.
5. Encourage legislators to assure continued support of existing health services and to increase funding in critical areas.
6. Establish a data base on the incidence and prevalence of Fetal Alcohol Syndrome and Fetal Alcohol Effect.

Objective: By 1990, at least 95% of the women in any geographic location in Montana, regardless of ethnic or racial group or socio-economic status, will obtain comprehensive and quality prenatal care beginning in the first trimester of pregnancy and continuing through the third trimester.

Who is responsible:

Montana Perinatal Program, physicians, community health nurses, SRS, WIC Program, local health agencies, individuals, hospital boards, dietitians, third party providers, lay advocate groups, home trainers, health educators, legislators, Healthy Mothers/Healthy Babies Coalition, schools and teachers, low income groups, Level III hospitals outside of Montana who work with Montana's Level II hospitals.

Resources needed:

Public and private funding to ensure that all women receive prenatal care.

Steps to achieve the 1990 Objective:

1. SRS to change funding limitations to 185% of poverty.
2. Legislative mandate for private third-party payers to provide prenatal care.
3. Prenatal care should be defined in eligibility standards to include preconceptual counseling.
4. Outreach education.
5. Public education.

Comment: This is seen as the major objective developed by the prenatal group at the Governor's Conference.

Objective: By 1990, all women and infants in Montana should be served at levels appropriate to their need by a regionalized system of primary, secondary and tertiary care for prenatal, maternal and perinatal health services.

Who is responsible:

Hospitals, physician providers of prenatal care, nurses involved in prenatal care, hospital association, hospital administrators, hospital boards, Montana Perinatal Program, Handicapped Children's Services.

Resources needed:

Baseline data.

Funding for evaluation of Level 1 and 2 hospitals by Level 3 personnel.

Funding for infant transport to higher level hospitals.

Funding for women at-risk to seek prenatal care at Level 2 or 3 centers (i.e. maternal transport).

Funding for nurse practitioners and nurse midwives to provide prenatal care.

Funding for outreach education for nurses and physicians.

Steps to achieve the 1990 Objective:

1. Inventory and evaluation by Level 3 personnel of hospital services, equipment and staffing.
2. Monitoring and continuing education for lower level hospitals (i.e. on-going evaluation).
3. Maintain and enhance services provided by Handicapped Children's Services, especially maternal and infant transport.
4. Maintain and enhance outreach education for nurses and physicians.
5. Legislative mandate for public and private third-party reimbursement for nurse practitioners and nurse midwives.

Objective: By 1990, no Montana county and no racial or ethnic group in Montana should have a rate of low birthweight infants that exceeds 3 percent of all live births.

Who is responsible:

Public and private health care providers.

Resources needed:

Funds to support programs.

Funding for prenatal care.

Funding for drug therapy, hospital care, child care.

Steps to achieve the 1990 Objective:

1. Develop system to prevent low birth weight.
2. Public education.
3. Professional education.
4. Private education

NOTE: This objective is closely related to Objective 2. For this reason, this objective should be excluded from the 1990 Objectives being considered.

Objective: By 1990, the neonatal death rate (deaths for all infants up to 28 days old) in Montana should be reduced to no more than 3 deaths per 1,000 live births.

Who is responsible:

Public and private health care providers.

Resources needed:

Funds to support programs.

Funding for prenatal care.

Funding for drug therapy, hospital care, child care.

Steps to achieve the 1990 Objective:

1. Preterm Labor Prevention Programs.
2. Family planning education.

Objective: By 1990, Montana should have a system in place for comprehensive and longitudinal assessment of the impact of a range of prenatal factors (e.g., maternal exposure to radiation, ultrasound, dramatic temperature change, toxic agents, smoking, use of alcohol or drugs, exercise, or stress) on infant and child physical and psychological development.

Who is responsible:

Legislators, department vital statistics, physicians, university centers, public and private health agencies, hospitals, birthing centers, public health nurses.

Resources needed:

Funding for Centers for Disease Control.

Funding for Montana Perinatal Program.

Steps to achieve the 1990 Objective:

1. Establishment of risk registry in Montana.

Objective: By 1990, all pregnant women in Montana at high risk of having a fetus with a condition diagnosable in utero, should have access to counseling and information on amniocentesis and prenatal diagnosis, as well as therapy as indicated.

Who is responsible:

Public and private health care providers, legislators.

Resources needed:

Baseline data.

Public and private funding.

Steps to achieve the 1990 Objective:

1. Professional and public education.
2. Media awareness to present the issue.

Objective: By 1990, reported incidence of primary and secondary syphilis should be maintained to a rate of 2 cases per 100,000 population per year, with less than 1 case per 100,000 of congenital syphilis in children under 1 year of age.

Who is responsible:

Individual men and women, family planning units, private physicians, diagnostic and public health labs.

Resources needed:

Funds for education/information as a preventive measure.

Funds for treatment as a curative measure.

Steps to achieve the 1990 Objective:

1. All pregnant women should have a nontreponemal serologic test for syphilis, such as the VDRL or RPR test, at the time of the first prenatal visit. If she is at high risk, a second test should be performed during the third trimester.
2. For the infants born to high risk or positive mothers, cord blood should be tested for syphilis antibody and the results used as a baseline for follow-up.
3. Appropriate therapy should be provided the reactive mother and infant if the mother is positive for syphilis.

Objective: By 1990, the incidence of neonatal infection due to sexually transmitted agents, especially herpes and chlamydia, will be reduced.

Who is responsible:

Individual men and women, family planning units, health care providers, STD program, schools and other educational institutions.

Resources needed:

Baseline data.

Funds to educate/inform the general public and health care providers.

Funds to treat/cure STD's.

Steps to achieve the 1990 Objective:

1. Collect data on the current incidence in order to determine current levels from which reduction will be measured.
2. Ensure all citizens are provided correct information on STD prevention through public media and school education programs.
3. Provide Quality Assurance Guidelines for STD clinical care to health providers to raise the level of awareness of the impact of STD's on the mother and infant.
4. Ensure the best possible diagnostic services are available to identify STD's in the pregnant female.

Objective: By 1990, there will be a 50% reduction in the number of pregnant women who smoke as compared to the rate in 1984.

Who is responsible:

Hospitals, voluntary health agencies, local health department, cooperative extension service, private physicians.

Resources needed:

Current data regarding the number of women who smoke and the quantity smoked will provide a baseline against which any reduction can be measured.

Steps to achieve the 1990 Objective:

1. Support public information campaigns on smoking aimed at pregnant women.
2. Include smoking education and cessation in well child clinics, prenatal clinics, family planning and school health.
3. Work with professional and voluntary organizations to expand and increase coordination of smoking information and cessation.
4. Enforce and strengthen smoking rules and regulations in meeting rooms, conferences, and in public places.
5. Determine benefits and costs of anti-smoking policies, including taxation and deployment of insurance premiums.
6. Serve as a scientific and public information source to individuals, institutions, and organizations throughout Montana.
7. Develop, test and replicate educational programs designed to prevent the onset of smoking and encourage pregnant women and smokers in general to quit.
8. Study factors that influence whether a woman smokes during pregnancy.
9. Explore the effects of passive smoking on the preschool populations of Montana.
10. Refine and encourage adoption of school health education curricula modules on smoking.
11. Examine areas of regulation - increased disease specific information in advertisements, deglamorizing the visual and printed advertisements, requiring greater visibility of warnings, requiring tar and nicotine levels on packages; and banning distribution to minors.

Objective: By 1990, the proportion of Montana women who breastfeed their babies at hospital discharge should be increased to 75% and 35% at 6 months.

Who is responsible:

WIC nutritionists, local health agencies, hospitals, private physicians and clinics, dietitians, Healthy Mothers/Healthy Babies Coalition, LaLeche League, LaMaze and other child birth preparation programs.

Resources needed:

Baseline data.

Funds to expand education and promotion activities in breast feeding to professionals and the general population.

Steps to achieve the 1990 Objective:

1. Acceptance or assignment of the responsibility to actively coordinate promotion of breast feeding in Montana.
2. Education for professionals on the advantages and benefits of breast feeding (workshops, materials, etc.).
3. Widespread involvement of professionals, media, institutions, organizations, workplaces, etc. to educate and promote breast feeding.

Objective: By 1990, the proportion of pregnant women in Montana with iron deficiency anemia (as estimated by hemoglobin concentration early in pregnancy) should be reduced to 3.5%.

Who is responsible:

Physicians, clinics, public health agencies, schools, Healthy Mothers/Healthy Babies Coalition, WIC programs, dietitians/nutritionists.

Resources needed:

Funds and commitment to provide nutrition-related information to the general public, especially adolescent females and women.

Steps to achieve the 1990 Objective:

1. Provide nutrition information and its relationship to health to the public, schools, etc.
2. Use media to emphasize importance of iron in food supply -- natural and fortified.
3. Emphasize counseling skills for those working with pregnant women.

Objective: By 1990, low birth weight babies in Montana (5½ pounds and under) should constitute no more than 2.8 percent of all live births.

Who is responsible:

Montana Perinatal Program, local public health agencies, private physicians, health care providers of prenatal care, voluntary agencies for preterm labor prevention, family planning programs, employers through the insurance programs they offer to their employees, nutrition programs, and individuals.

Resources needed:

- Funding for access to prenatal care.
- Funding for preterm labor prevention programs.
- Funding for family planning outreach programs.
- Funding for health educators/coordinators of preterm labor efforts.
- Funding for a high risk registry.

Steps to achieve the 1990 Objective:

1. Community involvement in creating their own preterm labor prevention programs. These programs should be administered locally. A community public health nurse should be available in each county. Community health nurses are a cost-effective way of providing basic prenatal services and education, and for screening for high risk conditions.
2. Identify people in high risk groups and enlist their active support and involvement.
3. Determine what is the baseline public knowledge of problems, and educate the professionals who deal with the high-risk populations.
4. Institute public relations program to raise public awareness.
5. Initiate preterm labor prevention projects across the state.
6. Educate public and professionals about behaviors that increase risk of preterm labor, including technical data about tocolysis for professionals.
7. The health curricula in schools should be upgraded and should reinforce positive lifestyle behaviors.
8. Institute financial incentives for pregnant women with positive lifestyle behaviors.

Comments: All women have the right to early prenatal care. Improving the access to early prenatal care is the best way to prevent low birthweight. A guarantee to this right would be a system of prenatal care that eliminates financial and geographic boundaries.

The steps to achieve the objectives listed here must be prioritized and funds should be allocated according to those priorities.

Objective: By 1990, all Montana women who give birth should have an appropriately-attended safe delivery by a licensed person, provided in ways acceptable to them and their families.

Who is responsible:

Legislators, health care providers, professional licensing agencies, individuals, Montana Perinatal Program.

Resources needed:

Funding for alternative birthing centers.

Funding for nurse midwives.

Funding for prenatal care.

Steps to achieve the 1990 Objective:

1. Survey birth certificates to see who is doing the delivery of babies in Montana. (The present birth certificate is inadequate.)
2. Registration and/or licensing of lay midwives. (Dissenting opinion suggests that registration is acceptable, but licensing implies a basis of competency that is required to protect the public. Supervision or monitoring of lay midwives was also suggested.)
3. Determine how many of the non-physician deliveries were high risk.
4. Determine if the deliveries provided by lay midwives should/could have been provided in another way.
5. Legislation to strengthen malpractice review panel by permitting the panel's opinion to be allowed into court testimony.
6. Support for the concept that having a baby is a medical event and should be under the purview of the state. (Currently, childbirth is not considered a medical event in Montana. A dissenting opinion suggests that childbirth should not be considered a medical event since pregnancy and birth is not a state of illness.)
7. Out-of-hospital deliveries should be (1) encouraged to be geographically close to hospitals, (2) considered only with adequate screening for high-risk conditions, and (3) included in any review of maternal and infant morbidity and mortality.

Comments: A state-level determination should be made as to what are appropriately attended deliveries. Maternal and child health professionals need to decide the issue of appropriately attended deliveries before requesting legislative action. No consensus was reached on this objective.

Objective: By 1990, Montana's infant mortality rate (deaths for all babies up to one year of age) should be reduced to no more than 6 deaths per 1,000 live births.

Who is responsible:

Public and private health care providers.

Resources needed:

Funds to support programs that establish and fully utilize community health nurses.

Funding for prenatal care.

Funding for drug therapy, hospital care, and child care.

Steps to achieve the 1990 Objective:

1. Reduce parental smoking and promote healthy lifestyles in general.
2. Develop a system to prevent low birthweight, including preterm labor prevention programs.
3. Public education (such as strengthening the curriculum of parenting classes and family life classes in the school curriculum).
4. Professional education.
5. Private education.
6. Continue support for regionalization of perinatal care, including transport of infants and mothers.
7. Continue funding for genetic counseling.
8. Establish a system to support good parenting and to prevent and counter child abuse (identify high-risk families, post natal support by public health nurses, hot lines).
9. Require autopsies on all unexplained infant deaths.
10. Improve nutritional status through proper food consumption to prevent birth of low birthweight infants.

Comments: The impact that Sudden Infant Death Syndrome (SIDS) has on infant mortality may not be changeable, but we need to know the rate.

Objective: By 1990, all infants in Montana shall leave hospitals in car safety seats.

Who is responsible:

Individuals, parents, public and private health care providers (obstetricians, nurses, pediatricians, hospital administrators, childbirth educators), teachers.

Resources needed:

Funding from automobile companies.

Public funding.

Private funding.

Steps to achieve the 1990 Objective:

1. Educate public.
2. Reinforcement by health care providers.
3. Change laws.
4. Enforce laws.
5. Every hospital should develop, in coordination with any interested community organization, a loan or rental program for car safety seats.

Comment: The state should focus on education as the means to accomplish this objective.

A method of measuring this objective should be implemented. Also, an infant safety seat could be included as a billed item as part of the services of a hospital's maternity program.

Objective: By 1990, the state shall organize a system in which all infants in Montana should be able to participate in primary health care that includes well child care; growth development assessment; immunization, screening, diagnosis and treatment for conditions requiring special services; appropriate counseling regarding nutrition, automobile safety, and prevention of other accidents such as poisonings.

Who is responsible:

Public health agencies, state health agencies, individuals, automobile dealers, automobile manufacturers, registered dietitians, Women, Infants and Children Supplemental Food Program (WIC).

Resources needed:

Public and private funding.

Steps to achieve the 1990 Objective:

1. Professional and public education.
2. media information.
3. Initiate valid data collection to determine quality of well child care.
4. Educate people on the advantages of well child care and encourage their participation.
5. Initiate mandatory third party payor coverage for well child care.
6. Ensure that each Montana county has access to a public health care giver trained in well child care.

Comments: The immunization program is being undermined by lack of insurance coverage for the service and by rising vaccine costs.

The most cost effective way to provide access to many of the components of well child care is to expand the number of community health nurses (CHN) in the state to do local well child clinics. With appropriate training the CHN could provide less expensive maternal and child services and could participate in the program to do some aspects of screening.

Objective: By 1990, in Montana Rhesus hemolytic disease of the newborn should be reduced to below a rate of 1.3 per 1,000 live births.

Who is responsible:

Public health agencies and private health providers.

Resources needed:

Public and private funding.

Steps to achieve the 1990 Objective:

1. Develop a reliable data base.
2. Public and professional education.
3. Endorse the adoption of a new birth certificate to enhance data collection.

Comment: This objective was not viewed as a major problem area.

Objective: By 1990, no Native American populace in Montana should have an infant mortality rate or a fetal mortality rate in excess of the Caucasian infant mortality rate or fetal mortality rate.

Who is responsible:

Indian Health Service for reservation Native Americans, urban Indian programs, Medicaid, private insurers of urban Indians.

Resources needed:

Funding for Native American population who do not reside on a reservation.

Coordinated effort between federal, state and local agencies.

Steps to achieve the 1990 Objective:

1. Require autopsies on all unexplained infant deaths.
2. Continued diligence in screening for gestational diabetes and the appropriate management of diseases.
3. Development of community awareness and advocacy for child welfare issues.
4. Development of juvenile codes for tribal courts and provide education to tribal judges about child welfare issues.
5. Redirect priorities to fund expanded community health nursing staff to be involved with more preventive health issues surrounding prenatal care and family planning.

Comment: The rate may increase due to current and proposed federal expenditure reductions.

Objective: By 1990, the maternal mortality rate in Montana should not-exceed-5 be 0 per 100,000 live births for any county or for any ethnic group.

Who is responsible:

Physicians, hospitals, emergency medical system.

Resources needed:

Access to medical care without geographic or financial barriers.

Steps to achieve the 1990 Objective:

1. Continue maternal mortality review committees.

Comment: Maternal mortality rates should be described to distinguish those deaths due to such circumstances as suicide or motor vehicle accidents. Including such deaths erroneously affects the death rate and obscures the impact on maternal mortality due to good prenatal care, use of seat belts and positive lifestyles.

More specifically, maternal mortality rates should be broken down into obstetric related causes and non-obstetric related causes. Obstetric related deaths should be zero. Motor vehicle accident related maternal mortality should also be singled out since seat belt use is a proper indication of successful lifestyle behavior presented as part of prenatal care.

Objective: By 1990, all Montana primary health care providers should advise patients about the importance of safety belts and should include instructions about the use of child restraints to prevent injuries from motor vehicle accidents as part of their routine interaction with parents.

Objective: By 1990, all Montana health facilities will ensure that all newborns return home in a certified child passenger carrier.

Who is responsible:

Primary health care providers, health facilities, parents/guardians, Montana Department of Highways, law enforcement agencies, service clubs, automobile insurance companies, Triple A, WIC, Montana Automobile Dealers' Association, Montana Department of Justice (Traffic Safety Division).

Resources needed:

Steps to achieve the 1990 Objective:

1. Attain a 100% use level for infant and toddler restraint systems by 1990.
2. All infant and toddler seat rental programs should be coordinated with hospital or civic organizations to provide immediate service to the newborn and make parents knowledgeable about these programs.
3. Attain a belt restraint usage level of 50% for all Montanans through public information and education.
4. Pass a mandatory seat belt law during the 1987 legislative session, and insure it will be enforced.

Comment: The mandatory and enforced seat belt law is seen as a priority.

These objectives cover the same issue as the objective on page 40.

Objective: By 1990, reported cases of these vaccine preventable diseases will be:

- a. Measles: Maintained to less than 5 cases per year.
- b. Mumps: Maintained to less than 5 cases per year.
- c. Rubella: Maintained to less than 5 cases per year.
- d. Congenital Rubella Syndrome (CRS): Maintained at 0 cases per year.
- e. Diphtheria: No more than one case per year.
- f. Pertussis: Maintained to less than 5 cases per year.
- g. Tetanus: No more than one case per year.
- h. Polio: Maintain paralytic polio at 0 cases per year.

Who is responsible:

Private physicians, local public health agencies, schools, day care providers, voluntary and professional organizations, individual parents or guardians, the SDHES Immunization Program, Office of Public Instruction.

Resources needed:

Funds to provide vaccines through public agencies.

Funds to develop and distribute educational material.

Funds to support personnel (local and state) to monitor diseases and the implementation of preventive strategies.

Steps to achieve the 1990 Objective:

- 1. By 1990, all mothers of newborns should receive instruction prior to leaving the hospital or after home births on immunization scheduled for their babies.
- 2. By 1990, at least 90 percent of all children should have completed their basic series by age 2 -- measles, mumps, rubella, polio, diphtheria, pertussis and tetanus.
- 3. By 1990, 97% of children in licensed day care and kindergartens through grade 12 should be fully immunized and 100% should be in compliance with state law.
- 4. By 1990, an immunizable disease reporting/surveillance system should be in place with 100 percent of reported, suspected and confirmed cases logged and investigated within 24 hours as appropriate.

5. By 1990, influenza and pneumococcal vaccines should be available to high risk populations through local public health agencies.
6. By 1990, at least 50 percent of people in populations designated as targets by the Advisory Committee on Immunization Practices (ACIP) should be immunized within 5 years of licensure of new vaccines for routine clinical use.
7. By 1990, mass immunization campaigns shall use delivery systems already in place, and shall adopt plans to individual situations.
8. By 1990, all persons should obtain and maintain an up-to-date official immunization record from their health care provider.
9. By 1990, no comprehensive health insurance policies should exclude immunizations.

Objective: By 1990, at least 90 percent of Montana children identified with Lead toxicity in the 0 to 5 age group will have been brought under medical and environmental management.

Objective: By 1990, the prevalence of lead toxicity among children ages 0 to 5 should be eliminated from virtually all Montana communities.

Who is responsible:

Montana Department of Health (Air Quality Bureau), and private health care providers.

Resources needed:

Steps to achieve the 1990 Objective:

Air Quality Bureau will require implementation of emission control techniques on all significant sources of airborne lead. This will ensure that state and federal ambient standards for lead are met.

Comment: This area is not seen as a significant statewide problem. Only 1 child is currently identified with blood lead toxicity, and East Helena is the only site being monitored in Montana. Perhaps limiting the scope to lead only precludes other heavy metal toxic agent problems.

Objective: Through 1990, continue the Montana Poison Control System and increase the amount of public information and education regarding the use of the system.

Who is responsible:

Public health agencies, physicians, pharmacists, hospitals and families.

Resources needed:

Continued funding for the telephone answering, professional resources and educational services of the Rocky Mountain Poison and Drug Center and for the production and dissemination of public educational materials within Montana.

Steps to achieve the 1990 Objective:

1. Continue annual negotiated contracts between State of Montana and Rocky Mountain Poison and Drug Center.
2. Expand public education efforts in area of poison prevention.
3. Continue professional education efforts in area of current treatment of poisonings.
4. Increase public and professional awareness and use of the system through all available educational means.

Objective: By 1990, 95% of all children 3-6 should receive the benefits of dental education and screening, and the voluntary fluoride mouth rinse or tablets should be provided for the 44,000 children K-6 attending school systems where the drinking water fluoride concentration is below optimum (0.7 ppm).

Who is responsible:

The Dental Health Bureau of the Montana Department of Health and Environmental Sciences, Office of Public Instruction, local county superintendents, school district administrators and teachers, the Montana Dental Association, local health departments and county and school health nurses, nutritionists, physicians, WIC program, schools, SRS (EPSDT Program). Carroll College Dental Hygiene School has also provided valuable assistance.

Resources needed:

State funding resources should be maintained at the present funding level of approximately 82,000 per year for the Dental Health Program under the Montana Department of Health and Environmental Sciences.

Continued in-kind voluntary participation of the dentists belonging to the Montana Dental Association statewide is needed.

Toothbrushes, fluoride mouth rinse supplies, dental screening forms, and dental education materials for school reference materials must be maintained.

The state needs to obtain data of the dental health condition of 7th grade students statewide.

Steps to achieve the 1990 Objective:

1. The 1990 Objective has been met for the most part. To maintain the present level of success, constant monitoring and consultation is to be provided by the Dental Bureau Chief. This person must also maintain the coalitions and networks developed statewide.
2. Follow up is needed to assure that children in need of treatment get the required services. When funding or access is the problem in obtaining dental treatment, the dental bureau chief assists the local coalitions and county health departments to solve those problems.
3. The program must maintain awareness for members of the legislature so that they receive and understand the facts pertaining to the benefit of the statewide dental program.
4. Designate and train a person in each school to administer the fluoride program. This person could be the school nurse who would be capable of not only administering the fluoride program, but also could supervise and facilitate the education, screening and follow-up of a comprehensive fluoride program.

Objective: By 1990, all communities in Montana having a population of over 1,000 should be on optimally fluoridated drinking water supplies. (0.7 - 1.2 parts Fluoride per 1,000,000 parts water).

Who is responsible:

The executive, legislative and judicial branches of state government, city and county government, dentists basically the Montana Dental Association, physicians, and health care providers especially local and county health departments. Also state agencies such as the Department of Health, Social and Rehabilitation Services, and the Office of Public Instruction.

Resources needed:

Initial first year funding is needed for equipment and the installation of this equipment which would cost approximately \$500,000. These funds would assist 43 cities over 1,000 population to receive and install the needed fluoridation equipment.

Steps to achieve the 1990 Objective:

1. The Department of Health, the Montana Dental Association, physicians, Montana League of Cities and Towns, Social and Rehabilitation Services, Office of Public Instruction, and local and county health providers would solicit support from the governor.
2. These same entities mentioned in step 1 with the Governor's support, would promote and write legislation making fluoridation mandatory statewide for all cities over 1,000 population who are on a public drinking water supply. The Department of Health should take the initiative in developing the needed legislation.
3. Having favorable legislation, the Department of Health would provide engineering and technical assistance to the cities implementing the fluoridation units.
4. The Department of Health, basically the Water Quality Bureau, would monitor and assist local city engineers to maintain optimum levels.

Objective: Part A: By 1990, the incidence of obesity, anemia, and retarded growth of infants and children will be reduced.

Who is responsible:

Parents, physicians, public health agencies, nutritionists, WIC and other food assistance programs -- both public and private, schools, day care, SRS, food stamp program, well child clinics.

Resources needed:

Baseline data.

Additional funds for outreach efforts in WIC, school lunch and public health agencies to provide nutrition education, information on resources available and food if necessary.

Steps to achieve the 1990 Objective:

1. Commitment or assignment to actively coordinate promotion of nutrition education and food assistance programs in Montana.
2. Education for teachers, physicians, nurses, day care personnel on the principles of adequate nutrition.
3. Involvement of schools, day care, food assistance and public health programs and professionals in providing nutrition information and/or food.
4. The incidence of specific nutrition-related disorders must be observed as an indicator for this objective.

Part B: By 1990, based on the assessment of nutritional status and dietary practices, appropriate dietary practices for infants and preschool children will be promoted among parents and selected community personnel, such as health providers, child care staff, food service workers, and social service personnel.

Steps to achieve Part B of the 1990 Objective:

1. The following indicators must be evaluated to determine if the objective is being accomplished:
 - a. Use of protocols for management of nutritional problems.
 - b. Availability and utilization of nutrition education programs.
 - c. Availability and utilization of dietary counseling services.
 - d. Provision for special supplements, dietary products and feeding implements, e.g., special spoons, feeding chairs, etc., especially for the handicapped.
 - e. Utilization of food assistance program(s).

- f. Improved dietary practices, e.g., decreased use of low nutrient or "junk" foods; and increased use of foods which promote better dental health.

Objective: By 1990, the mean serum cholesterol in children in Montana (aged 1 to 14) should meet recommended levels.

Who is responsible:

Parents, physicians, public health agencies, schools, dietitians.

Resources needed:

Baseline data.

Funds and commitment to promote nutrition education as it relates to serum cholesterol.

Steps to achieve the 1990 Objective:

1. Determination and acceptance of relationship of cholesterol and heart disease.
2. Educate professionals in ways to influence dietary habits to lower serum cholesterol. (Counseling skills.)
3. Provide counseling needed to alter food choices.
4. Involve media, schools, health programs, etc.

Comment: This objective is not a major concern.

Objective: By 1990, injuries and deaths to children in Montana inflicted by abusing parents should be reduced at least 25% from 1982 rates.

Who is responsible:

Social and Rehabilitation Services, teachers, law enforcement, Bar association, churches, mental health centers, parents, private foundations, local health departments, Indian Health Service/Tribal Policy Board, day care centers, teachers, ministerial associations, social workers, counselors.

Resources needed:

Baseline data.

Additional funding is needed by Social and Rehabilitation Services to expand services provided at state and local levels. The Governor's Task Force on Child Abuse/Neglect should make recommendations on action steps for progress in Montana.

Steps to achieve the 1990 Objective:

1. Design protocols for teachers to deal with suspected cases of child abuse
2. Assess the effectiveness of various types of existing child abuse/neglect programs.
3. Convene a state conference to review progress in reduction of child abuse/ neglect and recommend further actions.
4. Encourage state and private funding for reporting and investigation, sponsoring parental self-help groups, distribute information, and address needs of high risk groups.
5. Develop new public information material to assist communities in taking increased leadership roles in reducing child abuse/neglect.
6. Support activities aimed at developing and testing new primary and secondary approaches to child abuse prevention.
7. Strengthening mandatory child abuse reporting.

Comments: Steps 5 and 6 above are seen as predominantly efforts to be undertaken by the state.

Mental health is the priority here. The dysfunctional family must be addressed. Prevention in the area of mental health is a separate issue from the issue of child abuse and neglect.

CONFERENCE KEYNOTE PRESENTATIONS

Honorable Ted Schwinden
Governor of the State of Montana

During the course of the next couple of days, you're going to get some very valuable information. I'm here to simply welcome you and to try to encourage you to be serious, but not as serious as you are this morning. I've never seen a group of more dour expressions in my life. I know that we've got problems in the medical delivery system in this country, but by the time you leave here tomorrow, you're going to have those that affect Montana solved anyway, so you may as well go at that whole process with enthusiasm.

Before I begin to make a few comments about the importance of providing adequate and exemplary medical services and health promotion information on behalf of our kids, let me do two things very quickly. One is to thank all of you for participating, but most particularly to thank those people who have labored long and hard on the SHCC Council without a great deal of statewide recognition. The SHCC has had the willingness to participate in discussing areas that have moved to the front page of not only our newspapers but the whole issue of delivery of medical services at an affordable cost has been on the front of Time and Newsweek and every other magazine. To people like Dr. Listerud and his predecessor, Chairman Mel Williams, and all the other folks who have been willing to give of their time and their expertise to the Statewide Health Coordinating Council, I want to express my sincere appreciation as an appointing official, and more importantly, the appreciation of the people of the State of Montana.

Secondly, your being here I guess is totally relevant and in meeting in Washington with President Reagan and listening to Bob Dole and in discussions with other governors, it's clear that the problem of providing adequate medical care to our people, particularly in the Medicaid and Medicare areas, continues to occupy a very high level of concern at the national level.

I got off the plane in Billings on Tuesday evening, went over to Columbus for Capital-for-a-Day and one of the first items that came up yesterday morning were questions from the Stillwater County Medical Center people about the future of rural medicine in Montana and how we can continue to provide adequate support of our local medical care in small communities. That, of course, is particularly relevant to the topic that you're going to be spending most of your time on the next couple of days, which is disease prevention in regard to our kids.

I need some of that advice myself to share with my son and daughter-in-law, who have an almost two-year-old who has in his stomach an American quarter. It's not even one of the old silver kind. We're waiting patiently for something to happen, and it hasn't in the last several days. Obviously, in that case, prevention would have been worth, if not a pound, at least 25 cents. I've no idea what it costs to extract a quarter surgically. I'm afraid to ask.

I think you know, in my job, and this is particularly true in the last couple of years as our agriculture, mining and forestry situations have continued to put economic pressures on this state, that governors are normally

associated with ribbon-cutting and baby-kissing and things like that. But actually, we spend much of our time dealing with what I can only characterize as disagreement. That's the nice word for it. Governors really spend most of their time trying to find an acceptable and responsible middle ground between parties with conflicting interests. We're hired to be problem solvers. To be able to talk this morning just very briefly about health promotion is a very welcome change, because certainly no one quarrels with the need or desirability of attempting to improve the health of Montana's perinatal and preschool population.

The interesting thing -- and this was discussed in Washington, in terms of investment in our future of medical care and education -- is the dollars that you spend for perinatal care don't only benefit kids as the individuals who are most directly involved. Actually, the dollars wind up being investment in the future of our entire society. When every one of those tax dollars that is invested by improved prenatal care on a concerted basis saves the taxpayers another three dollars -- or \$3.38, I understand is the estimate -- that's clearly an investment that represents a very attractive rate of return. You can't get three for one in the market these days. It's tough to argue -- and that's why it's not confrontational -- healthy and happy babies are tough to argue against. That's all the more so if babies are actually cost effective, although I've found very few young parents who have talked to me about the cost-effectiveness of their children.

But unfortunately, the "why's" of preventive health care are really the easy part of what you're going to be discussing the next couple of days. It's the "how-you-do-it," the "how-to's" that present the major difficulties. Over these next two days, the obvious wide diversity not only of experience but of professional expertise that I can recognize in this room is going to have a tough task. You're being charged to develop the "how-to" part of healthy kids. Together, as you listen to speakers and discuss and debate and decide, you're going to be identifying and prioritizing what needs to be done in our state. As I said, that's no easy task, especially when you consider you're also going to be asked to do what I have to do, which is find the money to pay for the "how-to's".

No matter how convincing, no matter how dramatic and poignant the case, any group that seeks public funding these days must realistically expect increasingly stiff competition. The combination of what is really a severe national recession in about a third of our states (those which rely primarily on productive industries like agriculture, mining and timber), coupled with the dramatic drop in oil prices, have really taken their toll on states like Montana, the Dakotas, Wyoming, Utah, Colorado and clear into the mid-West region. Fourteen states now have already done what I've been forced to do -- to roll back appropriated levels.

If you add to the current uncertainty about what's going to happen to oil and our extractive industries and the uncertainty that surrounds the bitter and inconclusive debate that's going on in Washington over the federal deficit and tax reform, I think you can begin to appreciate the kinds of problems that legislators in Montana and these other states are going to face in 1987. Every time the price of oil drops one dollar on the market, it costs Montana \$3 million. It costs Oklahoma between 15 and \$18 million. It costs Texas \$100 million.

During the last legislative session, I gave a speech to one of the groups that came into the state. I gave a speech about the economics of government, in which I characterized the economy and the choices that need to be made as an equation. I said it's five plus five equals nine, nine being never enough money to go around anymore. If there's any change in that equation in 1987, I'm afraid we're going to have to reduce that equals number further than we did in 1985, as the demands continue to increase and the dollars continue to decline.

There were very few easy choices made by the legislature in 1985. There will be even fewer easy choices in 1987. Now, that's not to say that it's impossible to build on some of the successes that we've had; for example, in passing programs to train Montana hospitals in the care of special patients. What it is to say is that any future successes are going to require a coordinated and concerted effort from both the public and the private sector. Desirable changes or additions to state law are going to require that individuals and groups that are represented here today agree to draft and support -- and support very strongly -- their legislative goals. It's going to mean improved insurance coverage for prevention and require coalitions of concerted individuals who are willing to push for significant change. Securing funding for your State Health Plan is going to require that legislators be convinced not only that every dollar that you add to the health promotion budget is worthwhile but that the additional benefit that it provides is more important than what could be derived had you spent that dollar elsewhere in the institutions and the university system and in our school system, and so forth.

That health promotion makes good business sense I think is evident in the increasing willingness of the private sector to take the lead in this entire area of concern. Later this morning, I understand that Dr. Drynan is going to present five community health promotion awards to health care providers and community agencies for their own health promotion efforts -- efforts that have ranged from exercise and nutrition to use of seat belts to substance abuse.

Given the tremendous growing enthusiasm of those who are indeed committed to improving the health of our kids, I don't have any doubt that this conference and the cooperation and the initiative that I see here this morning are going to lead to significant changes in the health of all Montanans. I'm also convinced that your efforts can mean changes that result in a positive benefit to all of us.

Good luck in your deliberations. Thank you for the opportunity to welcome you back again, and now, get on with your good work. Thank you very much.

James Harrell
Deputy Director of the
Office of Disease Prevention
and Health Promotion
Department of Health and Human Services
Washington, D.C.

It's a real pleasure to be here. I've never been in Montana before, and that's a big pleasure, but this gives me an opportunity to express some very personal gratitude to Montana, using you as the Montanans to hear it. The reason is that I am the recipient of a Montana gift to healthy mothers and healthy babies every day of my life because a young Montana woman lives in my home and helps us with child care. This is a young woman who grew up in Helena and is taking a year off from Montana State University. And so I feel like I'm a recipient of a real gift from Montana and have heard a lot about you. I told the Governor that she is a terrific ambassador for this state, and there are a number of Montana young women in the Washington area doing this. And it really is something that's a positive thing, I think, for Montana. It's a very positive thing for us -- for my wife and me -- being middle-aged parents as we are of a two-and-a-half-year-old.

The focus of this Governor's Conference and the specific target of Montana's objectives are the years of preconception to age 5. Other speakers and your own work this afternoon and tomorrow will attend to that focus.

But I'd like to be a little more general, if you don't mind, and to reflect for a few minutes on the thinking behind development of the 1990 health objectives for the nation at the federal level as well as some of the lessons that we've learned and are learning still about using objectives as a form of health strategy for large populations. I hope that these will be useful to you Montanans in your objective building and implementation process.

What is kind of basic to the national objectives is a recognition that a lot of disease and far too many deaths at early ages are not inevitable. They can be prevented. And sometimes the agent whose power is greatest to effect that prevention is the victim of disease or a premature death, himself or herself. In other words, our own behavior is often our greatest health hazard. There's no question about it. Behavior does affect health. Sometimes drastically. Epidemiologic studies drawn from various societies show that social groups with dramatically different behavior patterns often have dramatically different health profiles.

From these studies, we have information that every one of the ten leading causes of death in this nation has its roots, to some extent, in behavioral patterns. The classic examples are well known, but it doesn't hurt to restate some of them. Cigarette smoking in this country accounts for more than 300,000 deaths every year. That's nearly a thousand deaths a day, one every minute and a half. People who smoke have in any given year about twice the prospects of dying as non-smokers, including for example, a ten-fold increase in risk for lung cancer death and twice the risk for death from heart attack, our nation's leading killer. The recent report from Dr. C. Arden Miller's committee that studied low birthweight for the Institute of Medicine pointed

out that 25 percent of low birthweight babies were attributable to maternal cigarette smoking.

Alcohol misuse is estimated to contribute to 100,000 deaths annually in the United States, including most of the more than 30,000 deaths from cirrhosis, which is the nation's sixth leading cause of death. Alcohol misuse is an important contributor to over half of all the deaths from traffic accidents, and to about a third of other injurious deaths. Moreover, women who drink during pregnancy are at twice the risk of having low birthweight babies, and fetal alcohol syndrome is a problem solely related to maternal drinking patterns.

Dietary factors are also believed to be important contributors to at least a third of all cardiovascular deaths and perhaps to as much as 35 percent of cancer deaths in this country. Two recent consensus conferences at the National Institutes of Health focused on the problems of obesity among Americans and of diets high in fat and cholesterol content, each of which substantially raises the risk of various health problems.

Stress, and the way we handle it, seems also to contribute to our individual profiles of health and disease. For example, social isolation, which is the way some people handle their stress, seems to be one of the most reliable predictors of high death rate, exposing people to the risk of death from all causes, which is two to three times the death rate for others in the community in a given year. Several studies have also shown that bereavement, at least for men, offers particular vulnerability to death in the year following the death of their wives. Although problems of workplace stress have not been definitively linked to specific health outcomes, they are increasingly viewed by scientists and employers alike as important issues of concern.

And there are a variety of other health-related behaviors that have impact on our health. Examples include seat belt use, sexual behavior, occupational choices and circumstances highly exposed to injury. Not all behaviors, of course, related to health are necessarily negative. Exercise seems to offer considerable protection from problems ranging from heart disease to osteoporosis to stress and depression. We don't fully understand the way this works yet, but there is a growing literature reporting these positive effects.

So all in all, there isn't any question about it -- behavior influences our health status. But there still are a lot of questions about what we as a society ought to be doing about it.

And that brings us to my next point, which is the role of government vis a vis health behavior. We talked a little bit about that last night in the question and answer period, the issue of health policy which seems to have sometimes the effect of limiting the area of individual freedom and the tradeoffs that are a part of that. Thomas Jefferson believed that the role of government ought to be restricted to the provision of those things which individuals are unable to provide for themselves. Well, that perspective raises quite conceivably a kind of contradiction -- the role of public health for decisions that are essentially very private.

Yet I think there is a very significant role for government, a very important role. There's a lot -- and this is not just government at the federal level; it's local, state, and federal -- a lot that they can do,

especially to enhance culture, the setting, the milieu that shapes the nature of individual health choices. And to a large extent, I think, the development and the tracking of health objectives are meant to be one kind of health education tool for doing just that -- for shaping that culture, for bringing the issues that those objectives address to the forefront of people's thinking.

At the federal level, much of what we do is related to policy development and consensus building. Examples certainly include the work of developing Healthy People, the Surgeon's General report that was published in 1979, on health promotion and disease prevention, and the subsequent work to develop 227 measurable objectives addressing 15 different areas of disease prevention to be achieved in this country by the year 1990. We're already beginning to think about how we can develop the objectives and get even better participation all across the country for the year 2000.

We also at the federal level focus a lot of attention on the development of scientific consensus around topics of interest for research and the public interest, such as obesity and cholesterol levels. Federal programs can sometimes mobilize efforts to improve the delivery of services as well, particularly when we're directly involved, as with Indian Health Service programs or community health centers. For matters of high national priority, federal economic incentives can be shaped through the use of tax policies or through the Medicaid/Medicare systems for reimbursing health care, though I have to say that these areas are places where we've seen a real inadequate application of the possibilities when it comes to health promotion and disease prevention. Federal regulatory efforts usually aren't seen as extended to the regulation of individual behavior, but they can affect them positively; for example, by requiring the labeling policies that require labels on certain consumer products, making it easier for the public to understand just what they are buying and how it might affect their health.

The most important federal contribution to health promotion and disease prevention activities is support for research, for expanding the research base for prevention activities. This is one area where the federal government is clearly a dominant participant and has a lot at stake in the integrity of the research enterprise. Our principal vehicle for this at the federal level is, of course, the National Institutes of Health. But more and more the Centers for Disease Control, Food and Drug Administration, and the Alcohol, Drug Abuse, and Mental Health Administrations play important research roles as well. Even in public education, the federal government has some limited programs. Examples include Healthy Mothers/Healthy Babies, which we started several years ago and now it's been taken up in this state and others in communities across the country; and this year, a similar effort with the healthy older people program, which is just getting started; and the pregnancy and smoking initiative announced by Secretary Heckler last summer following up on the Institute of Medicine's findings about low birthweight babies and smoking.

But the success of these efforts to provide relevant information to motivate people to change their behavior really depends on how they are implemented by state and local coalitions, in effect, how they are implemented by you. It's very clear that when it comes to facilitating behavior change for positive health outcomes, those who are in the best position to change attitudes about the ways in which individual decisions are made are those who

are located closer to where it happens. Programs at the local level have special opportunities to provide information about health risks through local public and private health providers, to enlist employers and schools in the effort, to pass supportive local ordinances like those related to clean indoor air or traffic safety enforcement (I understand Helena is discussing the possibility of a seat belt ordinance), to involve the considerable resources of voluntary organizations and specifically focus outreach efforts, and to recruit the involvement of local media for programming that is relevant to the health of their communities. So the successful implementation at any kind of federal level, and I suspect any kind of state level, too, really depends upon the development of a local infrastructure, a local coalition, a local ability to act and to put things into practical use.

We've made some considerable gains in the last decade or two against many of our most serious behavior problems. Smoking levels are down. Cholesterol levels have been reduced. Childhood injuries and deaths have dropped off, and even in many communities around the country, drunk driving fatalities have been reduced. Infant mortality rates have given us cause recently for renewed concern as the downward trend has slowed perceptibly and may even be turning around in some of the states. But those gains we've made and the gains we will make in the next four years leading to 1990 have come not because of any kind of monolithic federal effort, but as a result of local initiatives that embrace and carry forward the developing science base.

Now, that's all by way of kind of a backdrop for objective setting that we do at the federal level and that you're taking on here in Montana. As I said, we've been very immersed in that ever since the 1990 objectives were first put together about six years ago. And I thought I would just conclude what I have to say by ticking off quickly eight lessons that we've learned that you might find useful in your own objective setting and tracking process.

Lesson number one: You do need to set some targets and it really helps if those targets are quantified, if there are numbers. And you ought to set them pretty high. It's really okay to miss the mark but it's kind of embarrassing to set them so low that you get there next year when you're setting them for the year 1990. And we did that at the federal level. Anyway, those kinds of targets help you to be pro-active rather than the way the medical field has historically been, which is mainly reactive to what's going on, reacting to the trends.

Lesson number two: You can't do it alone, and you shouldn't even if you could. This should not be something that's left to the health and medical field. It really requires coalitions and lots of others; with private enterprise, with schools, with churches, with voluntary organizations, with anyone you can get to be interested in the health of their communities.

Lesson number three: You need to know where you are in order to be sure you're going where you want to go. Let me say it again. You need to know where you are in order to be sure you're going where you want to go, which means you've got to collect the numbers and analyze them and track your progress. And some people would just as soon let that kind of go by but it really is important to deal with those numbers as you go along.

Lesson number four: You need to make mid-course corrections when you find you're off course. We found that at the federal level with the 1990

objectives. We just kind of got off course either because the science base changed directions or because we just weren't headed in the right direction initially. So it makes sense to take stock about whether you're on course and whether adjustments need to be made.

Lesson number five: You really need to remember what it's all for and not let the process become more important than the results. That's easy to happen, too, and another reason why kind of mid-course taking stock is important to do. Remember that the final result is healthier people. It's not really those numbers that are helping us, but are just a means or a vehicle for helping us to get there.

Lesson number six is one we don't do so well at the federal level and it takes a lot of help from others: You need to put your money where your mouth is. Someone has looked at the national scene in terms of health costs and reckoned that we spend about four percent for prevention and 96 percent for treatment and cure, and that's a real imbalance that should be addressed.

Lesson number seven: You need to practice what you preach. The best health education, after all, still may be not all the words we put out but our own personal example of how we live.

And lesson number eight: You need to remember that you DON'T know a lot more than you DO know about health, so you need to keep on learning. And what we found is that the whole objectives process and tracking and using objectives as a kind of guideline and guidepost really does facilitate that continuing learning process that's so necessary for us to improve the health of communities and the health of individuals for whom you are responsible.

That's what I have to say. I'm really happy to be here and I'm looking forward to being a part, for the next day or so, of your process. Thank you very much.

C. Arden Miller, M.D.
Professor of Maternal and Child Health
School of Public Health
University of North Carolina at Chapel Hill

I'm delighted to be here and flattered that you would have me come all this distance to meet with you. I do it with a little trepidation because I'm not certain that my background and experience are as relevant as I would like them be to the issues that you're intending to address in Montana. I'm reminded a little of the story that is so old I'm hoping I heard it before many of you were born. It's about the farmyard rooster who wandered over and, for the first time, saw some turkey eggs. He was just enormously impressed with their size and their luster and they were just better than anything that he'd seen before. He went back to the flock and thought that he ought to take his hens over to look at those eggs and he did, and said, "Now, ladies, it's not that I want to complain, it's just that I think you ought to know what others are doing."

And it's not that I want to complain about what's going on in public health in Montana. From all of the data that I have seen concerning rates of low birthweight and infant survival and teenage pregnancies, you're doing much better than most of the parts of the country where I have worked, but nevertheless, we do share interests and I'm delighted to be here to share with you whatever perceptions I have that may be useful.

One of my abiding interests for some years has been a function for the official public health agencies of state and local governments serving as guarantors for the health of defined population groups, and by guarantors, I construe that they must work with other providers, facilitate, engage in casefinding, augment services, do followup, and when necessary, directly provide those services that are not otherwise provided by available provider systems, and to assure at least a basic cluster of essential health services on behalf of the entire population. It is the only provider system that I know that can assume that responsibility on behalf of a clearly defined population constituency.

That point of view about health departments serving as guarantors and when necessary as providers of care has been criticized from several perspectives. One is the point of view that so many departments are really not capable of performing those services, that their staffing and the competence is not sufficient to assume that role. Secondly, a criticism that it really introduces the concept of a public provider system working along parallel with what surely will continue to be a predominantly private system of medical care, and that if that public system assumes increasing responsibility for poverty level people, we ultimately will have a system of care in which we have a poor medical program for poor people, and one, which at times of economic constraint and cutback, will suffer and the people that they serve will suffer.

In response to those two criticisms, we've done a number of studies around the work of local and state health departments. These are studies which have involved not only national surveys but careful case studies of health departments across the country. I think that our response has been -- or our

impression has been -- that, number one, health departments are much more adequate and much more involved in those direct personal health services than they are often given credit for, and that more than half of the health departments in the country are involved as direct providers of personal health services to their constituency populations.

We find as well that the populations that they are trying to serve very often present such a complex array of both social and medical pathologies that they require interventions and supports and services that other provider systems can't readily marshal.

Finally, it has seemed to us that not only are a great many of these departments involved in personal health services, but many of them are doing it in exemplary fashion. It simply is not hard at all to identify a large number of health departments in every state in which we've looked that are fulfilling those functions in an exemplary way. The problem that we face is to strive for some kind of assurance that that guarantor's role is consistently and universally made available to the people of this country.

I look for evidence wherever I can find it that health departments are fulfilling this mission. Since 1981, with the increase in poverty levels and with the loss on behalf of many people of eligibilities for Medicaid and loss of benefits and loss of private insurance, there have been increased expectations and burdens placed on many health departments.

With this in mind, I welcomed especially an article that I commend to you in an early September issue of the New England Journal of Medicine by Lester Thurow in which he was analyzing health service systems in this country. Lester Thurow examined this whole issue of a two-tiered system of care and suggested that it did, in fact, present some problems, but went on to say that as far as he was concerned, that was not passe. We have moved beyond the two-tiered system of care. We, in fact, have a three-tiered system of medical care in this country.

Thurow identifies the three tiers of care as the traditional tier, in which people could pay out-of-pocket or from their insurance coverage for whatever provider system they might elect. This is our traditional system of care and that clearly would continue.

Thurow saw as a second tier of care those people who were locked into a provider system (perhaps a health maintenance organization or a provider system that was attached as a benefit of employment) and were assured a package of services and protective measures. But they have no choice as to the provider system that they would choose because that choice has been made for them by the capitation arrangement that they were involved in.

The third tier of care was the public system of care, that system comprised of local and state health departments and their services and the public hospitals. According to Thurow's formulation, it was the second and third tier of this cake that were growing most rapidly and that the third tier of public provider systems was growing especially rapidly because in this era of emphasis on privatization of services and competition for care, nobody was competing for people who couldn't pay. There are more of them now than we've ever had before, and there are increased expectations placed on public providers to meet their needs.

I know of no circumstance that's more poignant in relation to the need for organized public systems of service on behalf of the people who can't pay than in maternal and child health. Recent studies show that nationally, among women of the prime child-bearing years, more than 25 percent are completely unprotected by either Medicaid or by health insurance or by any economic coverage for their health services. Very few of those can pay the enormously inflated costs for routine maternity services and increasingly, they're looking to public providers for those services. Most health departments of my acquaintance that are attempting to provide prenatal care and to contract for or arrange maternity services are finding that they are overwhelmed by the increased demand of the public.

Thurow goes on to say that in these three tiers of care what we must do, and will be driven to do increasingly, is to define exactly what are our priorities. We simply will be forced out of economic necessity to assume the position that we can no longer be buying and paying for whatever it is that technology happens to be offering. We must begin to identify what it is that's most important for us and begin allocating our resources on that basis, but that market priorities will distort what it is. They will not necessarily, in this sphere, be the priorities that are most cost effective or most humane. I think our mission here must be to clarify our own thinking and develop our own justification and propose, in the most persuasive ways that we can, the preventive emphasis among those priorities no matter what the provider system might be.

So the thrust of my remarks today will be what we know about prevention in the fields of your interest (that being perinatal care and the early years of life), what we know works, and how those preventive efforts can be promoted.

I want to applaud the previous presentations that we've heard this morning with their emphasis on health promotion and disease prevention and what is embodied in that movement with the clear definition of measurable, time-limited objectives. The whole cause of preventive health and preventive medicine has suffered terribly in past decades because it's been such a warm, soft, cozy concept that it could embrace anything anybody ever wanted to do. You could justify open heart surgery as preventing something, just as you could justify whatever your favorite hobby, your favorite cause happened to be.

I think what health promotion/disease prevention has done for the country is to define for us measurable, clear-cut objectives on a timeline and forced us to think of prevention in more precise terms than we've ever done before. As was pointed out, there are 227 measurable objectives. It's unlikely that every state and every community is going to want to embrace every one of those and to use all of them as the guidelines for resource allocation, but they all have relevance some place. It's not necessary to embrace all of them because embracing a few of them provides a very potent organizing principle for planning and for resource allocation, an organizing principle which requires that there be some accountability as to what these new endeavors, what these new resources are going to accomplish some years down the road in very specific ways.

I want to urge your consideration of another set of closely related endeavors to those we find in health promotion/disease prevention. They are the community preventive health service standards, the so-called model

standards put together by CDC and a cluster of public health agencies -- the American Public Health Association, the city and state and county health officers. They were first proposed in about 1979 as a companion effort to health promotion/disease prevention. It was an effort to bring down to the community level the specific measurable outcome objectives for prevention.

Whereas health promotion and disease prevention largely is based on large population groups (objectives for the nation or for the state at large), the model standards were an effort to provide at the community level that same philosophy of prevention. Health promotion/disease prevention, as you know, is organized into broad programmatic areas on an age-specific basis linked ordinarily to patterns of morbidity and mortality. The model standards are linked to the more conventional programmatic organization of public health agencies and public health departments. There is a new publication out of the model standards, published just a few months ago. In that publication, there is an effort to link each of the community standards to the national objectives. I commend that publication to you because it is an approach that will bring this way of thinking for prevention down to small populations, small communities, counties, in a way that the health promotion/disease prevention objectives for the nation will not necessarily do.

Why is it that these two endeavors are so important to us? I emphasize some in terms of allowing some accountability, allowing some measure of progress, clear formulation of goals and objectives, but it really represents a different way of thinking about public policy in relation to health that in time will have a profound effect nationally and in our state and local governments. We have been through many decades of a kind of formulation that, if we accepted as a public responsibility the provision of more resources for health care, some kind of good things would happen as a result. If we educated more physicians, provided more hospital beds, had more of this kind of facility, that kind of facility, did more research and development, improved our know-how of disease and treatment, that all of these resources somehow would find application in useful ways.

Many benefits have resulted from that, but it's also been true that serious thinkers about health policies realize that a policy based on resource allocation left uncovered many populations that didn't necessarily provide the priorities that were most rational and were most cost effective. Compared to what other places were doing, this was very expensive. As a result of that, we went through a period in which we tried increasingly to influence the processes by which those resources were used: various kinds of planning agencies, various kinds of regulatory functions about redistribution of manpower through National Health Service Corps, redistribution of facilities and beds through certificates of need, advocating certain kinds of payment mechanisms based on the evidence that pre-payment and capitation payment promotes certain kinds of preventive services.

In all of this, once again, some benefits accrued, but the most serious planners in all of this persisted in asking the difficult question: "planning for what?" And the "planning for what" requires at every level of government a definition of the outcomes that we expect to be achieved.

I think the two initiatives that have been described to you provide you guidelines for identifying those outcomes. The next rational step will be to examine what are the linkages between those outcomes and the interventions and

the resources that are most rational, most cost effective, and can be held most accountable.

How are we doing? If one examines not measures of health of this country in terms of how many resources we have, if one examines not on the basis of how many visits or how many interventions or how many screenings, but if one examines it in terms of the outcomes and the health status measures (and I would report to you the findings of the project that was briefly alluded to earlier: the child health outcomes project, which was begun with Foundation support in about 1982) to identify, after extensive consultation with the health officials from all sectors of society, what are those measures of infants' and children's health that are most meaningful to us in terms of measuring trends in the health of those population groups.

We did this, once again, out of concern in 1982 for the very serious cuts that had been made in public health programs and in the financing of health care. You'll remember that the cuts that were made in children's programs were more serious, were more severe than cuts in any other kinds of programs that were proposed. Those cuts were made with the formulation that all we were doing is wringing the fat out of these programs. We can reduce the amount of money, we could even reduce the services, and isn't it nice that nobody's going to be hurt by it? What the child health outcomes project has been is an effort to measure over a period of some years what has been the impact of these changes.

We've come up with a dozen measures of child health. They are predominantly outcomes, but two or three of them are also process measures (such as immunizations) that are very clearly linked to identifiable outcomes. Those outcomes that we identified for newborns and infants are inadequate prenatal care, low birthweight, and infant mortality rates. Since 1981, the proportion of pregnant women receiving early and continuous prenatal care -- according to the best estimates that we've been able to determine -- has decreased by about ten percent. Low birthweight is a problem in this country, as we discussed at some length last night. It's a problem in aggregate for all populations because our proportion of babies born of low birthweight is higher than it need be and higher than for most other countries of comparable wealth and accomplishment. It is especially high for poverty-level populations and minority populations, being twice what it is for the Caucasians.

Low birthweight is responsible for about two-thirds of the infant mortality in this country, and though we do a better job in this country of causing low birthweight babies to survive than most any other part of the world, we pay an enormous cost for that (now, several billion dollars a year of public monies through neonatal intensive care units). Most estimates are that those units which now take care of about six percent of all newborn babies could reduce that caseload to as low as two to three percent if we were doing a better preventive job.

The infant mortality rates are a matter of great concern and I want to emphasize that it's a concern to us not only because we have a sentimental attachment to small babies and we think their deaths should be prevented whenever possible, but because the infant mortality rate is regarded pretty universally as one of the best measures we have not only of what's happening to babies but the quality of life of the families who are attempting to bear and raise babies. It's a proxy indicator of the way society takes care of

vulnerable people, so that there is much greater significance to infant mortality than whether or not a few hundred or a few thousand more infants survive, as justifiable as that might be.

It's been perfectly clear that again the infant mortality rate in this country for all populations is higher than it need be and higher for people of comparable national origin or socio-economic status than other parts of the world. Though that rate came down in a reassuring way during the 1970's, it's also true that since 1981 the improvements have slowed. The most recent data that I've seen have shown that it has almost completely plateaued. The rate for 1984 was about 10.6 deaths per thousand live births, and the provisional data for the first ten months of 1985 is that it's 10.5. We're not going to meet the national objectives that were defined that we felt so confident could be achieved by 1990. We're not going to achieve it, and it's going to cost us a tremendous amount of grief and a tremendous amount of money because we're not meeting it in coping with the low birthweight infants and the associated morbidity that's represented by that circumstance.

The indicators that we regard of special importance to children are inadequate immunization, and that's another difficult and sad story. In the late 1970's, CDC proposed that we probably could eliminate measles from this country, as smallpox has been eliminated worldwide. We were close to doing that through our measles immunization programs. We're doing a less adequate job of immunizing children now than we were in 1981 and measles has not been eliminated. It's increasing and it's particularly increasing in those populations of pre-school children and college-aged children that are the least-well immunized of any in our society. The problem relates not only to measles but to polio, diphtheria, and tetanus and the constellation of developing diseases.

The data that we take comfort in and that are so often quoted as far as immunizations are concerned are the immunization rates for five- and six-year-olds. That's easy because most states have laws that require that the children in that age be immunized before they go to school. What's more important is what proportion of the two-year-olds are immunized. That's the vulnerable age group. Once again, we're talking not only about preventing the specific diseases that those immunization agents protect against, but one could look at immunization rates as proxy measures of the proportion of two-year-olds who are under some form of well child supervision, getting not only immunization but checks on growth and development and some anticipatory guidance about other health issues. The rates of immunization for two-year-olds nationally have declined, particularly again for the increasing numbers of poverty-level children and minority groups.

When we speak of poverty-level children, bear in mind that's not a small group of children. That represents one in four children in this country at the moment. As the rest of the country has experienced a reassuring improvement in economic indicators, children have simply not participated in that economic revival. The proportion of children living in poverty has stayed at the highest level that they've been since 1960.

If one could select only one measure of how a population of children is doing as far as their health is concerned, particularly preschool children, I suspect the measure that you would want to pick is growth rate. We don't do a very good job of measuring. Growth rates are important for an individual

child because if an individual child falls off the line that they have established as their usual growth pattern, it ordinarily means that there is some illness or some cause for that. But if a population of children fall off the line -- if instead of having three percent of the children growing at the three percent growth rate, you've got 15 percent of the children growing at that growth rate -- it means clearly that that population of children is malnourished; it means that they are suffering from infestations or other kinds of developing illness.

Again, we need to monitor preschool-aged children's health more carefully with better-organized assistance of sampling for their growth rates. Insofar as that has been done, we find that improvements which have been well documented during the 1970's have tended to reverse. Elevated blood lead level is a problem in many parts of the country with older housing and is a problem in some parts of the country, including this one, where there are mining industries and smelting industries that present an environmental hazard. We know that among preschool children, as many as one in five will have dangerously elevated blood lead levels.

What's a dangerously elevated level? We keep changing the definition of that because it now is perfectly clear that any lead in the blood is dangerous. And the more there is, the more dangerous. CDC has recently just lowered the level at which there ought to be careful medical evaluation for the possibility of brain damage and other difficulties.

But the problem that we face increasingly with blood lead levels is that our screening systems and reporting systems have tended to deteriorate. We simply don't know anymore as much as we used to what proportion of preschool children are being screened and what those screenings reveal.

Non-motor vehicle accident fatalities is another of the measures that we found is important for preschool children. Although a statement was made earlier today that there's been reduction in accidents, that's not true of the non-motor vehicle related accidents. These are accidents that have largely to do with the quality of the home, with the amount of supervision there is in the home and, particularly with both parents working, the kinds of care the preschool children receive during times both parents are gone or the kinds of supervision they receive during the important hours from three to six when school lets out and before parents get home from work. Those accident rates for preschool children are increasing and they reflect increased concern about some environmental aspects of the quality of living circumstances and supervision for very young children.

Motor vehicle accidents, important at all ages and especially important for early teen-age and teen-age populations, is one of the leading causes of death and disability for that age group. Yet they are decreasing. But there's a funny phenomenon about their decreasing. I'm told by the people in our Highway Safety Institute that highway related motor vehicle accidents can plot almost exactly along the same curve as the economic cycles of the country. As the economic cycles go up, so do the automobile-related deaths and disabilities, and as the economic indicators show a downward trend, so do the deaths and disabilities. No one knows for sure why that is, but the supposition is that it's because of changes in the amount of recreational driving that young people do. At any rate, because of the serious recession

since 1981, we've seen less recreational driving and less motor vehicle related accidents.

Births to school-aged mothers I won't dwell on because this comes in some respects outside the span of your interest, but in other respects it doesn't. Children who are having children are a very important consideration in perinatal health and preschool health. We now experience somewhere about 12 to 13 percent of all of our infants born in this country to teenagers. I want to say more a little latter on about what that means and what can be done about it. It has devastating effects, not only on the mothers in terms of their health and their economic and social wellbeing in the future, but effects on the infants in terms of birthweight, in terms of increased rates of disability, in terms of SIDS death, in terms of terribly distressing recent reports about a much higher rate of unexplained deaths among infants of teenage mothers than we've seen before, and concerns about abuse and neglect.

Two other indicators are iron deficiency anemia (showing increases related to nutritional problems) and child abuse and neglect (clearly increasing, and increasing most dramatically in those states, counties, and metropolitan areas of high unemployment, giving evidence that anxious, frustrated, concerned adults spending increased hours at home represent a hazard to their children). Bear in mind once again that unemployment rates for households with small children remain at distressingly high levels.

Now, I want to compare briefly these trends of child health outcome measures during our most recent recession with the last previous recession that the country experienced during 1974-1975. Those two recession periods were roughly comparable in terms of the unemployment rates and certain other economic measures. They were very different in one other major respect. 1974-1975 was precisely the time when most health services and social supports in this country were most dramatically expanded. Those were the years of the most dramatic expansion of WIC, of Medicaid, of AFDC, of food stamps; and, insofar as we can determine in reconstructing infant mortality rates and rate of low birthweight, there were no serious adverse trends in children's health during that recession period. What happened during 1981-1982 is that those protective supports and services underwent their most dramatic retrenchments and we've seen adverse effects. I don't think there's anybody who would claim that the complex, jerrybuilt system of health services, social supports and welfare protections that we have in this country are the best that anybody could conceive. They're put together through a complex system of compromises, but the evidence is that during 1974 and 1975 they worked. They worked to protect vulnerable people. If we want to improve those services, we have to replace them with something better because if we simply take them away, the evidence that we have since 1981 is that infants and children will be enormously adversely affected in the ways that we've described.

I want to spend most of the rest of the time available to me talking about the infant mortality rate and the rate of low birthweight, because I think it's the best handle we have immediately for changing services and social policy to make a difference in the health of infants and children in this country. It's worthwhile to spend some time examining what are the determinants, what are the things that are associated with low birthweight and high infant mortality, and what do we need to be addressing?

I've mentioned the neonatal intensive care units. That's been the way that this country -- and probably the most expensive way that we can conceive -- has addressed the problem of high infant mortality and low birthweight. Most expert neonatologists that I've talked with report that though we can expect new advances in technology and improvements in this field as we have in all fields of medical care, that it is unlikely that we can expect any further improvements in the care of low birthweight infants that will substantially alter national statistics beyond what we have now. They also report that it is unlikely that we can or should attempt to move down to the four- and five- and six-hundred gram babies using technology to preserve their lives in the expectation that they will produce robust, healthy, vigorous, preschool children and older children. I don't mean to be minimizing at all the important work that those units do, but I think it's unlikely that we can expect a great deal more from them.

A second concern -- a circumstance that relates to low birthweight and infant mortality (and we talked about this some last night, but I'll mention it only briefly for those of you who were not here) -- that we often hear is that this is a special problem in this country because of the heterogenous nature of our population. European countries that don't have the complex mixture of ethnic origins and racial groups have an easier time. I think that's true. But it's also true that there is no reason why every segment of our population cannot enjoy the same favorable outcomes that are experienced by the bulk of the people. I cited and cite again the evidence from Scandinavia of the large numbers of Turkish, Yugoslav and Middle Eastern people who have migrated to Scandinavia, attracted there by the employment opportunities. What's so remarkable about those populations is that they end up having the same favorable outcomes in terms of birthweight and infant mortality that the indigenous Scandinavians have. We could do the same here.

The black population in this country presents a special problem and no one knows still the extent to which that problem is related to differences in educational levels, in socio-economic levels, and in persistent failures in access to essential services. But there is no credible evidence that the enormous difference in infant mortality rates and birthweights between the black and white races exists on a purely biological basis. If one corrects for educational levels and socio-economic levels as the levels improve for black populations, so do all of these important outcomes.

It's also true that even at high socio-economic levels and high educational levels, there is a small persistent difference between black and white populations that we as yet don't understand. That's led some people to speculate -- and it's purely speculation -- that as a result of many generations of deprivation, black women have gone through a selection process that favors those who bear small children. There's no evidence to support that. Equal in speculation is that even as blacks in this country improve their socio-economic levels and improve their education, they are subjected to stresses that have adverse effects. I want to dwell more about the possible effect of stress a little bit later.

There is the speculation or the justification that one occasionally hears that one of the reasons that we're slowing down is that we're getting so good, and that as we improve our records, we will have a kind of plateauing effect. Many people take comfort in that, but it's nonsense. If we were experiencing a plateauing effect, one would expect to see that effect most dramatically in

the segments of our population that have the lowest and the best rates. That's not what's happening. The people who have the best rates are the ones that are continuing to show the most improvement. It's the people who have the highest rates of low birthweight and infant mortality that are showing the most profound slowing, and even reversal, of those rates.

The unmarried state is a difficult issue that we don't understand and though it's a circumstance that's receiving a lot of recent attention, it really is not new with us. The proportion of women giving birth to infants out-of-wedlock has been growing at a very steady rate since about 1970 and without a lot of recent change, but it's reached levels now that are terribly disturbing. About 20 percent of all white children are born out-of-wedlock and about 50 percent of all blacks are born out-of-wedlock. Though we know of no biological reason why an unmarried woman can't have just as healthy a pregnancy and healthy a baby as a married one, the truth is that all of the data are dramatically worse for the unmarried population in terms of birthweight and infant survival. I submit to you that whatever those reasons are -- whether it's lack of emotional supports and services or lack of economic security or whatever -- that this is a population which very clearly needs more services and more community interventions and more supports rather than fewer.

I want to say a word about teenage pregnancies, and to share with you several recent studies that I think are of great interest. The data about teenage pregnancies in this country show that there is really beginning to be a falling off in teenage childbearing. That falling off appears to be due to improved access to abortion; there is not really a falling off in teenage pregnancies. The Alan Guttmacher Institute within the past year has been examining and releasing many interesting international comparisons about teenage pregnancies, and the results are just fascinating.

We have the highest teenage pregnancy rate of any part of the western world exceeded only by Rumania or Hungary or someplace in Eastern Europe. It's a lot higher -- possibly twice as high -- than for most countries of Western Europe. The results of the Alan Guttmacher Institute indicate that that is not because our young people are more sexually active or are sexually active at an earlier age than in European countries. They could find no differences in that. They could find no differences in the age of onset of first intercourse, even from middle class white populations as compared with European countries.

The difference is that European teenagers engage in sexual activity with better recourse to contraception than is true in this country, that the programs of sex education and access to contraception are clearly far more extensive (accepted without the social stigma or the social embarrassment that so much characterize those services in this country) and the programs of sex education are routinely available in schools at an early age without question or conflict.

You are familiar, I am certain, with a lot of the conflict that is associated with efforts to introduce family life education programs in the schools in this country and the concept of the school-based clinics that provide health care and even contraceptive information and devices. But I want to share with you an experience that will be recorded in the March or April issue of Family Planning Perspectives about an experience in Baltimore for the

impact of a school based clinic and of a school-wide sex education program. Two schools were selected in Baltimore for study schools, and two comparable control schools were studied at which there were no programs introduced. This was done in about 1980 and the data covered a five-year span. In the study schools, there were not only sex education programs but there were clinics that provided counseling on a number of health issues that included sexual patterns and practices and also provided contraception.

Five years later, the study schools showed a dramatic reduction in abortion rates of the teenagers and a dramatic reduction in pregnancies for the teenagers. But the most important finding of all was a delay (by as much as 12 to 14 months at every age group through the teens) in the age of onset of first intercourse. That is the only carefully controlled study that I know of that is responsive to the issue that is so frequently raised, that being if you teach teenagers about sex and make contraception available to them all you are doing is promoting promiscuity and they will do it in an irresponsible way. What this study suggests is that if you give information to teenagers and if you give resources to them, they apparently have a greater sense of self worth, a greater sense of security, and they don't do it. Or at least they don't do it as early as they did.

I suspect that the answer to teenage pregnancy must be the expectation that most of these women will become sexually active, that most of them will become pregnant and will become parents, and what we must work very hard to do is to delay, insofar as we can, those events. It seems to me so important and so urgent in a society such as this one where teenagers are beleaguered -- as the rest of us are, only some of us aren't in the position to be as responsive as teenagers are -- by sexual messages about sexual activity. We sell Chevrolets and blue jeans and everything under the sun by promoting sexuality, and then wonder why in the world it's a problem to us.

The other contributing factors to low birthweight and infant mortality I won't dwell on at such great lengths. Several were mentioned and they're well known. Cigarette smoking, next to minority status and poverty, is one of the most important correlants of low birthweight. We know some things now about cigarette smoking that we didn't know before. We know that any amount of cigarette smoking is harmful during pregnancy; that the more a woman smokes the more harmful it is; that if she stops smoking, that has benefits; that if she stops smoking at the onset of her pregnancy, she still has problems that are more serious than the woman who has never smoked but fewer problems than if she kept on smoking.

Alcohol is a serious problem, and we simply don't know yet how much alcohol or when in pregnancy it is most dangerous. I think the best thing to say about this is that any alcohol during pregnancy appears to be dangerous.

Weight gain continues to be a problem. We're not very many years away from the circumstance in which women were encouraged to gain no more than 20 pounds during pregnancy. If they were obese, they were put on rigid, restrictive diets. Everyone agrees now that pregnancy outcomes are much more favorable for women who gain at least 20 pounds or more during pregnancy. If a woman has a weight problem, pregnancy is precisely the worst time to attempt to cope with it. That practice is not as serious as it once was, but it could be a problem.

Stress is worth spending a little more time on. I mentioned it in relation to blacks. I want to try to differentiate the evidence around two kinds of stress. One is the emotional stress that comes with some kind of a life crisis, a death in the family, a loss of a job, or some other circumstance. There are pretty good studies, one done a number of years ago in which a group of several hundred pregnant women and a control group were followed during pregnancy. It was found that those who experienced some very stressful event during their pregnancy had smaller babies, premature onset of delivery, and poorer pregnancy outcomes than those who did not have a stressful event. The study also found that those women who had a stressful event and who had some kind of supportive structure around them (whether it be an extended family or a particularly supportive spouse) and adequate services and care, that their outcomes were improved. It was the isolated stressed women who had the worst impact. Again, this emphasizes the importance of supportive, continuous services as early as possible.

Physical stress is not quite so well accepted or well understood, though it's beginning to be clarified and clarified most dramatically by the work of an obstetrician in Paris. His work is just fascinating. He makes the assumption that pre-term births (that is, labor that begins too early) for the most part are predictable and are preventable. Within the first five minutes of the first prenatal visit, it's possible to identify most of the risk factors that relate to the possibility of low birthweight and premature onset of labor.

He believes the most important stress variables are: employment that requires a lot of standing, a lot of lifting, a lot of fast moving, some professional or occupational activities such as nursing, sales people, factory workers. His study suggests that nurses, for example, have three times the onset of premature contractions or premature onset of labor as school teachers. He suggests that work itself is not a risk factor, but the kind of work the woman engages in is the risk factor. That is supported by some evidence in this country that women who have sedentary jobs have better birthweights than those women with factory jobs that require standing. If women have jobs that require standing or fast moving or lifting or bending, the results are worse.

This Paris obstetrician found that those women who were employed throughout their pregnancy in what he called high risk jobs had about 7 percent low birthweight babies. Those who were employed at low risk jobs had only a 4 percent rate of low birthweight.

Now, what did he do with women who had high risk jobs and who threatened early labor? He removed them from their work, had them stay home, and sent a midwife into the home for a 30-minute visit one time a week. The women were not confined to bed but they rested from their work. He found that he was able to reduce by one-third the proportion of women who went into premature labor and whose infants were required to stay in the intensive care unit.

With all of these correlants and with all of these things that we know about low birthweight, what can we do programmatically? What ought we be translating into our own communities? What really works? Neonatal intensive care units, regionalized care and fast transport of women who are in labor if they're high risk works. Maternal and infant care units, the comprehensive health services that were begun for pregnancy women largely under the auspices

of health departments in the 1960's, work. They are important for a number of reasons. Those maternal and infant care units were not costly. The per capita costs for their comprehensive care, including all administrative costs, were about the same as for fragmented care in adjacent census tracts.

But what was so important about their findings is that, whether in central Appalachia or in inner cities, they were able to take the highest risk populations (some of whom have infant mortality rates above 50) and bring those rates down to 10 and 12 and 14. What's so remarkable about that is that they did it without necessarily changing the life circumstances of the population they were dealing with. These were still largely uneducated populations. They were still largely poverty level. What this means is that we don't have to wait for some utopian ideal where ignorance is eliminated and racism is eliminated and poverty is eliminated. We know how to render comprehensive health services on a community basis to high risk women and the way to make important changes.

Organized smoking cessation programs for pregnant women work. Careful studies have shown that women who smoke who participate in such organized programs have babies that weigh on the average 95 grams more than women who smoke and don't participate. Alcohol cessation programs work. Stress reduction programs work. The nutritional supplementation programs and educational programs under WIC work. Those participants have better records of early participation in prenatal care. Their babies have a better birthweight, better head circumference, and the babies who are born to women who participate in WIC have less chance of requiring hospitalization in the first year of life than those who have not participated.

Prenatal care works, and I'm going to stop and talk a little bit about prenatal care. We know a lot in this country about the timing of prenatal care, which pregnant women enter care at which week or month of pregnancy and we know a lot about how many visits they have. We know nothing about what goes on during those visits, and whether the woman is being cared for by an attending, listening provider who gives a lot of counseling about risks and smoking and nutrition, or whether it's a Medicaid mill that brings the woman in the front door and collects the urine specimen and does a blood pressure and talks to her for 30 seconds and puts her out the back door and collects the Medicaid fee. Those all show up the same way on the birth certificate that we have.

We need to do a tremendous amount more to find out what goes on during prenatal visits and what the content is that relates to more favorable outcomes. We know without a doubt that women who enter care early and stay in continuous care have better outcomes, but we also know that a lot of high risk women are not participating. Only about 60 percent of black women participate in prenatal care during the first trimester and only about 80 percent of white women participate. As you begin looking at other high risk women, say teenagers (one of the highest risk populations that we deal with), only one in five enters prenatal care in the first trimester. That's understandable. This is the population that wants to keep their pregnancy secret as long as possible or denies that they are pregnant. But we need a much more open attitude about providing women help that they need.

Insofar as we have standards about prenatal care (and we don't have much), those standards relate to efforts to cope with toxemia in pregnancy. Hence,

the emphasis on blood pressures and urines and weight and ankle swelling. The standards present a schedule of visits that suggest we ought to see the women at monthly intervals early in pregnancy, then at biweekly intervals, and, late in pregnancy, at weekly intervals. If you stop and examine all of the risk factors that I've suggested to you that are important in preventing low birthweight and premature labor and infant mortality -- smoking, alcohol consumption, nutrition, stress -- they're all factors where the intervention needs to be early in pregnancy. We ought to be seeing high risk women at weekly intervals as early in pregnancy as possible, and saturating them with all the counseling and all the supports and interventions at that time. It simply is assinine to think that we can change the behavior and provide the supports and services that they need with monthly visits and then accelerate to weekly visits after the damage has been done.

Income transfer programs work. I doubt that we're going to initiate a social policy that will implement this, but the simple truth is that if you get more money to poor women, they have better babies. An income transfer program in Gary, Indiana, showed that the birthweights of babies who participated in that negative income transfer program were on average 500 grams more.

In closing, I want to cite several interesting studies, the first by Grossman and the second by Korman. They attempted to examine on a county-by-county basis where programs were implemented and where they were not during the 1970's, and those programs that seemed to relate best to the dramatic reduction in infant mortality.

Grossman initially studied, through the late '60's and '70's, Medicaid, maternal and infant care programs of comprehensive community-based services, access to family planning for preventing unwanted pregnancies, abortion thwarting unlimited childbearing, and unlimited access to the new contraceptive technologies. He found that among those public programs -- Medicaid, maternal and infant care, family planning, and abortion -- the one that had the most dramatic effect on reducing infant mortality was access to abortion. The one that had the second most dramatic impact was access to family planning. Preventing unwanted pregnancies clearly led the pack.

Korman went back just a year or two ago and repeated these studies and expanded the list of things that were investigated. This time, the list included abortion, neonatal intensive care units, differences in schooling levels, Medicaid, family planning, participation in WIC, participation in maternal and infant care, and access to comprehensive neighborhood health centers. From that study, she found that what contributed most to improvement of infant mortality during the 1970's for black populations was access to abortion. What contributed next was access to neonatal intensive care units. For white populations, the most dramatic impact were changes in schooling and participation in WIC.

It seems to me what this means, if we're going to address the problems of low birthweight and infant mortality in this country, is that we must do a better job to help women control and prevent unwanted childbearing. We must do a better job of providing early and continuous services to those women who elect to bear children. We must do this as a matter of social responsibility on an organized community basis in every community where there are women

bearing children. I think that our present piecemeal approaches simply are not adequate for the high risk women that we need to deal with.

Thank you ever so much.

Kyla Thompson
Vice President, Brum & Anderson
Denver, Colorado

I really am very honored and pleased that you asked me to speak to you today. I do have two other speeches so my apologies to those of you who have heard this before. This is all Don Espelin's fault because he was at a conference in Denver. It was a media panel and we really had a very lively debate. It was really very nice that Don asked me up here to Montana because I have a big love for your country and for your state. My husband and I have toured your state a lot, and even though it's on a motorcycle, we may have seen it as well as you have.

My job right now is with a public relations agency, and we have a lot of different clients other than health. For instance, we have the Denver Broncos, and they are really a different client for me, and we have a lot of real estate clients.

What would relate to you the most today is my experience at Children's Hospital in Denver. Children's Hospital in Denver, as most of you know, is a regional pediatric health care center. It was a wonderful career for me. I didn't have to leave. I wasn't fired. But I did leave because the emotional toll was a lot on me over those years. We did so much media and I lived through over 40 major crises. I just felt really beaten up after awhile. It was time to move on.

But the memories I have of Children's and the experience that I want to share with you today is what I think might help you in some of your programs. And believe me, the experiences that I share with you today are 20 years of experience. They're not all my personal opinion. They're based on a lot of good, solid research and I just know they work, so trust me. A lot of things I'm going to tell you today I know work.

A lot of people don't realize that toxic shock syndrome was discovered by a physician on the staff at Children's Hospital in 1978. I like to tell this story because, for someone in my profession in particular, it's a wonderful story. It's something that happened to me that I would never have dreamed would have happened to me in my career. I had just begun work at Children's and I began nagging the medical staff immediately about telling me what they were up to (because my job, obviously, was to "image" the hospital, which is what public relations is in a very simple term).

One day Dr. Todd called me on the phone and said, "Well, Kyla, you keep telling us that you want to hear what we're doing. I'm doing something but I don't know if it's news or not." I said, "Well, Dr. Todd, why don't you come over and sit down and let's talk about it." So he walked in, and I remember being struck by how young he looked, since he was head of Infectious Disease at Children's. I didn't know him very well. He sat down and I began, "Well, what are you up to, Dr. Todd?" He replied, "Well, I don't know if it's news but I just discovered a new disease." That's exactly what he said. I remember to this day what went through my head. It was: When in my lifetime would I meet someone who discovered a new disease? I don't even know how you do that.

It was just incredible. I said to him, "Un-huh, that's news. That's a good start." I was just trying to contain myself. I asked, "Well, how did you do that?" He offered, "Well, there were a lot of children coming into the hospital and there were some areas that weren't diagnosed that I wasn't comfortable with. I put a team together and for the last year we've researched a disease. It's been accepted by my peers and it will appear in the New England Medical Journal next month." I said, "That's terrific. Congratulations. I'm very proud of you. What are you going to call it?" He responded, "Well, I thought about Todd Syndrome, but I guess the team wants to name it toxic shock syndrome." And I said, "Don't do it. Keep Todd Syndrome."

That's really the first time in a long time that I had some forewarning. So we put together a public relations and communications plan, had a press conference, and the rest is history. It was about three months later when the CDC, based on a study done with 40 women, made the connection between toxic shock syndrome and Rely Tampon, and our phones lit up. I answered over 2,000 media calls on that day. I was scolding Tom Lacher here, from CDC, that they should have given us some advance warning they were coming out with the wire.

(Tom Lacher from the audience: "The phones were busy")

(Kyla Thompson in response: "That's true.")

By the time I left Children's Hospital toxic shock syndrome alone had required my staff and I to answer over 8,500 telephone inquiries and deal with over 5,000 media, including international media. I went to everything from the Today Show to you name it, and Dr. Todd now is a chief witness all across the country.

Toxic shock syndrome isn't funny, but we had some funny times with it. For example, the time a man called and was sure that it was the Mediterranean Fruit Fly coming from the Philippines that Marcos was sending over that caused toxic shock syndrome. We'll see, with Marcos in Hawaii, if toxic shock syndrome has declined now.

I've mentioned already to you what public relations is. I've given you a few hints of what it really is. I don't think a lot of people really know what public relations is and what marketing is, because I see them exchanging those two words. I want to just preface my remarks with a little bit of a description to you that will frame some of my comments later on.

Public relations is a management function. It's a function that identifies the publics that are important to an organization or to a company or to an individual. It identifies those publics so that it can then form its policies and procedures to reach those publics. It's a two-way street. You want the publics that are important to you to feed back to you what their needs are. You do this in public relations -- this two-way exchange -- through a lot of public relations tools. That can include publicity, which is media placement. It can include special events, community relations, publications, word of mouth, and advertising. Those are tools of public relations.

Marketing is another story. Many people will say, "I'm going to go out and market this" or "This is an idea and I'm going to go market it." What they really mean is that they are going to publicize it or promote it. Marketing is much more product oriented. Marketing is when you go out to your

consumers first and you do a market research survey and you find out what your consumers want. Then you come back and build the product according to their needs, wants and desires. That's really, in its true sense, marketing.

The best description I've ever found for marketing is the Fats Waller song called, "find out what the people want and give it to them just that way." I've never found a better description.

Now, there is a big component of marketing that's promotion and publicity, and that's where people get the two confused. It's not important that you know that, but it's important that you know it in reference to my remarks.

The most important thing is something that you've been discussing here for two days: you have issues, you have concerns, you have causes. Now, how are you going to get your issues out there to your publics and how are you going to get that couple that I affectionately call Joe and Betty Sixpack to listen to you? That's the remainder of my talk to you today -- some tips to you and things that have worked for me on how to reach Joe and Betty.

But before I give you the tips, you should know something about Joe and Betty. Joe and Betty Sixpack, along with you and me by the way, are receiving seventeen thousand messages a day. Think about that. Seventeen thousand messages a day is what we are all receiving. Whether it's a label, whether it's a personal conversation, whether it's the media, whether it's a sign, whether it's something from a supervisor or underling. That's how many messages we are receiving.

How are you going to get your message and what you've discussed during these last two days to Joe and Betty? How are you going to get them to recognize your message above all the rest of them? That's really tough. You're in a helluva lot of competition.

What you do is position your remarks. You position your statement so that it has a little touch of an angle of a difference so that Joe and Betty remember it. There are a lot of ways you can do that -- positioning your message and positioning your product. There are two excellent examples in America right now of companies that did that, and this might help you understand more about what I'm saying.

The Seven-Up company, when they began advertising their product about 15 years ago, did their research first and they realized that they couldn't take on Coca Cola, so they positioned their product as the un-cola. That's positioning yourself in the marketplace. It's a beautiful example. Avis did the same thing. Avis did their research and knew that Joe and Betty thought Hertz was number one, so they thought, all right, if you think Hertz is number one, we'll be number two and we'll try harder. It was one of the most successful campaigns in history.

This is something you have to remember with Joe and Betty. First of all, you have to identify the publics that really mean something to you. Do you really want to talk to everybody out there? Is everybody really your public? Is Joe and Betty really your public? That's the first thing that you've got to do -- make sure that you understand who your target audience is. Until you know who those people are, how are you going to find out how they get their messages and how are you going to reach them? If you do a shotgun approach

with your limited time and money, you're going to lose a lot of your time and money. Target in on your specific publics and audiences first.

Now I'm going to tell you something about Joe and Betty that you have to trust me and believe. Your issues and your concerns right now will always mean more to you than they ever will to Joe and Betty. That's sad, but that's true. I'm not trying to make Joe and Betty out as apathetic, but remember, Joe and Betty have 17,000 messages a day. Why should they care about yours? Why should they? What's in it for them? It always boils down to that when you're trying to reach someone. What's in it for me to care about your concern and your cause?

The third tip I'm going to give you is to do research. Research the attitudes, opinions, and perceptions of your audiences. Research does not have to be synonymous with long lengths of time and great amounts of money. You can do research by having three or four focus groups of your targeted audience sitting in a room and ask them questions. Do you really know what your audiences think?

We will sit in these conferences, because I've sat in them with you and I've sat in my own conferences, and we will say, "I talked to so-and-so down the street and she says that her daughter got pregnant and this is what she thought and this is where she would go and this is what she would do." And we think, "Aha," and end up building a whole program around that one person's opinion.

You are not objective about your issue anymore. You're too close to it. I will tell you and I will promise you that you really don't know what your publics think until you ask them themselves. And you have to ask them in an objective way. I'm not even sure that you could write a survey that would be objective because you might just incidentally word something that will solicit the remark you want to receive, not the one you probably should get. That's why it's hard for you to do personal interviews. You probably, in your body language, would do something that would solicit the remark that you want to receive, not maybe a remark that you should hear.

If you can do research on Joe and Betty and find out what their attitudes and opinions are first, that's going to help you. A good example of this is the Edsel. Ford Motor Company did do their research. They did ask the American people, "What do you want in a car? What's your dream car?" And they said, "Oh, well, it's this kind of grill and this kind of fin and this kind of bumper." So the Ford Motor Company went out and built the Edsel. And nobody bought it. You know why? They forgot to ask the people in the survey if they'd buy it. That's a true story. They went from the desires but forgot to ask the people if they would buy it. Relate all of this to your programs because I think there's a relationship.

The biggest thing that I've already said and I will emphasize through some examples is to give Betty and Joe their message in a way in which they receive them. This is the biggest mistake people make. Do you think Joe and Betty read? Do you think if you put all of your announcements and publicity in the paper that Joe and Betty read it? I'm sorry to tell you, they don't. They can't. A lot of them can't, and a lot of them that can, don't.

So why do you spend all this time publishing these reams and reams of paper that they can't understand? What do you think Joe and Betty do? They listen. They do listen. Here's an example of this point.

After about two years with Children's Hospital, the medical director came to me and said, "Kyla, I want to offer free clinics and testing for all of the young black mothers and children for sickle cell anemia." Naturally, I replied, "That's wonderful. Great. That's a really good thing to do." So we immediately got together a committee. I walked in and found the docs very, very dedicated to this project. Do you remember when sickle cell anemia, about eight years ago, was quite (and still is, by the way) a scary disease? But we had little education in those days. The doctors said, "Look, we want to back you 100 percent. We want full-page ads in the Rocky Mountain News. We want full-page ads in the Denver Post. Whatever you need. We want those mothers in here." But I said, "Thank you for the support, but I'm not going to use a full page ad because I know black mothers don't read the Denver Post and the Rocky Mountain News." I then had an education session with them. Two of the most powerful underground networks in this country right now are blacks and women because they have historically been ignored by the old boys' networking. Who do you think started the Civil Rights movement? Do you think it was the media just all of a sudden picking up on it? The Civil Rights movement, even before King was thrust as the leader, started in black churches. It is an incredibly powerful network.

I said to them, "I'm going to do flyers and I'm going to go educate and talk to the church leaders in Five Points," [the predominantly black area of Denver] "and get their help and post flyers in every church in Five Points." We also then knew that black people in Denver listen to one radio station. It was KDKO Daddy Soul, and Daddy Soul was a wonderful character. I met with Daddy Soul and I told him what we were doing. He said, "I'm behind you 100 percent and I'll plug it on the radio 24 hours a day."

Do you see what I'm getting at? That's all I did. I had flyers in churches and Daddy Soul. My budget was \$200. We had 2,000 women come in that weekend because we sent the messages in the way in which they get them. We targeted our audience and targeted our dollars and targeted our energies.

Another wonderful example is that Children's Hospital had historically ignored the teenage population. We all felt that. So we decided to do research to see if there was a need to put in an adolescent medicine center. What we found out will be relevant to a lot of you in dealing with teens right now.

We did our research in the shopping malls because in the big cities the teenagers hang out in the shopping malls. In fact, they call themselves the mall rats. So we thought, why not do our mall intercept interviews around Christmas time. We placed our four research people in the four shopping malls at Christmas. We surveyed teens by themselves, teens with their parents, and parents by themselves. What we found out will shock you. What we found out confirmed some of our suspicions, but absolutely shocked us in some other ways. What we found out from the research was that, had we not done the research, we would have gone in the wrong direction to the tune of about \$200,000, because we didn't really know what teens thought. I want to tell you that every doctor and every nurse in that room swore to me that they knew what teenagers were like. But the research proved us wrong in some areas.

This is what we found out. We found out that Mom and Dad and the kids don't read things. But if they do read, what do you think is the number one national magazine read by women between the ages of 19 and 49? Family Circle? Red Book? Reader's Digest? That's it. Reader's Digest.

What is the number one national magazine read by teenagers? TV Guide? Seventeen? Rolling Stones? People? Time. Yes, Time Magazine. Would you have ever guessed that? They subscribe to it for their current events in school. They're subscribers. This is why research is so crucial.

What do teenagers spend more time doing? Reading, listening to the radio, or watching TV? Who spends more time listening to the radio, Mom and Dad, or teens? Mom and Dad did. They listen to the radio commuting. Mom, as she worked inside the home, had it on all day. Mom and Dad working had it on all day. The kids were in school, see. It's incredible. We built our entire promotional campaign around radio for Mom and Dad. We targeted our dollars. We identified our publics.

To address the problem of Children's Hospital ignoring the teenage population, we thought, how are teenagers going to get down to the Children's Hospital? If you've never been in Denver, the hospital is in the inner city. How are those kids going to get down here to us?

We talked about shuttle buses and we talked about free bus tokens. We were going to go out and buy buses and put \$40,000 into all of this. In the survey when we asked teenagers and their parents if it would be difficult for them to come down to Children's Hospital, not a single one said transportation was a problem. They said if teens want to go somewhere, they'll get there. If Mom and Dad think that their teens are being helped by a doc down in the inner city, they'll drive down there. They'll go there for the service. Now, look what would have happened to our funds if we had not done the research. So I hope you get my drift. I think it's crucial for you to really understand who Joe and Betty really are.

The fifth tip I'll give you is that public relations begins at home. This is a big group and I don't know you, but I know that you have dissension. I know that you argue. I know some of you want to go this way and some of you want to go that way. I know that all of you are after the same cause and the cause is bigger than all of us. But you don't ever air your dirty linen to Joe and Betty because they don't care. They don't want to hear it, and it really makes you look bad. Public relations starts at home first. You are the ambassadors and the best ones for your cause. If you don't pull together and if you aren't a strong front, then you're not going to convince Joe and Betty of anything. This is true of every group I have talked to because it's so indigenous to a group coming together for one cause.

This is a statistic that you should remember: One good experience or one good remark is repeated six times; one bad experience or one bad remark is repeated 12. Think about that, okay? I used to say in the hospital that it didn't matter how much wonderful media was used to image the hospital, it only takes one rude doctor, one impatient nurse, and one nasty admissions clerk to nullify a whole lot of what my staff and I were doing. Word of mouth is the strongest advertiser. Word of mouth still carries faster than anything else. You've got to remember that.

The best compliment to my staff and me occurred when we hired a new psychiatric nurse. I met her one day in the hall and I said, "Welcome. I'm glad you're here. I've heard of your reputation. We're real pleased to have you on staff." She replied, "I hear you're the PR lady. You know, the biggest reason I wanted to work here was that this seemed to be the hospital that had the most fun and the neatest programs and the one I heard about the most." I said, "Thank you. Then I've done my job." That was a great compliment to my staff and to me because we had created this image of the hospital. It was true, because remember, if it's not true, Joe and Betty find out fast.

The sixth tip I have for you is to sell the human aspect of your cause, not always just statistics and hard facts -- because Joe and Betty don't care about your statistics. They care about the teenager who's got a baby who's handicapped, about the single mom, about the kid down the street, about something they can relate to. Now, statistics are important. This newspaper article says "Teen child bearing costs nation \$16.6 billion in 1985." That's an astounding statistic. That's astounding and that would impress Joe and Betty. But what will impress them more is if you break it down and tell Joe and Betty how much it comes out of their pocketbook. What's in it for them? Why should they care? Break it down so they can relate to it.

Humanize your issues. Humanize your causes and concerns. I never sold Children's Hospital. I never sold the bricks and mortar. I never sold the administration. I sold those kids and their families and their stories. I can promise you I never dramatized a thing because there was a story there every single day without faking any of it. All I did was facilitate those family stories to the media and that's what they wanted to hear. They didn't want to hear that we were \$6 million in indigent care debt. They didn't want to hear the statistics. They didn't care. But they did like those tear-jerker stories because that's what they relate to.

People respond three ways. People respond emotionally and through their pocketbook and through humor. They respond the quickest those three ways. The emotional response is where I get into a lot of arguments with some other people in my profession, so this is my personal opinion: I think you should use emotion. I think you should pull the stops out and you should stop trying to protect your publics from seeing the reality of what a sick newborn looks like. I think you should take a four-color picture of a sick newborn that weighs a pound and a half and has a needle and a tube coming out of every orifice of its body, and you ought to blow it up. You ought to put it in front of every young mother you come across. Because you know what? That's what a sick newborn looks like.

You can't sugar-coat the reality. You can't protect the public from that. If they see reality, that's going to stick with them far more than any words you ever say to them. Why do we, in this business, continually try to cover up things? I'll tell you two examples that illustrate this better.

I was giving a tour once to a society group of women in Denver that were very active in Denver and raised a lot of money. They had a lovely luncheon and I was to tour them through the hospital afterwards. We have a huge oncology department and, unfortunately, there were over 600 children being treated for cancer at that time. When I took these women through the oncology center, we had about 15 inpatient kids. Actually, the kids were pretty

upbeat. They were sitting at their beds with their families and playing. Of course, they had no hair and they were thin. They were sick. After we rounded the corner one lady came up and in a very loud voice she said to me, "I don't want to see that again. That made me sick. I don't want to go through that kind of thing. I don't like seeing those kids without hair." I don't know how I restrained myself, but I turned to her said, "That's what cancer looks like." Now, think about that. What did this woman expect to see? That is what cancer looks like.

The same thing happened with child abuse. We had many, many child abuse cases one year. I wanted to dedicate a total quarterly publication to the problems of child abuse and to the prevention of child abuse. We really debated, and on the cover we finally put a picture of a little boy who had been burned by his stepfather. He had been submerged in hot water, which is a very popular form of child abuse. We decided to put that picture on the cover. It was not a picture that exposed the little boy to the point where it would have been embarrassing. It was not a picture that was a full frontal or back view. It was a picture of the nurses treating him and you could see the rawness of the burns. As you all in the health industry know, there's hardly anything more painful or worse looking than a burn. I put that on the cover. I got a lot of calls; I had a lot of complaints. The fundraiser down the hall came running and he said, "You didn't have to do that. People can guess what child abuse looks like. I mean, for God's sake, you didn't have to put it on the cover and cram it down their throats." But I said, "That's what child abuse looks like."

Out of that publication formed a coalition of mothers that now run Child Health USA. That is the one picture that prompted them to realize how serious it was, how awful it was, how disgusting it was, and that they wanted to do something about it. That one picture they attribute to that. That's why I defend my opinion that you've got to use the emotion in your industry. Why are you protecting people? Why not? Do you think you can shock Joe and Betty now? Do you think, after going through Viet Nam and everything that we see on TV, that you could shock? I can't even shock my 13-year-old anymore. He's seen it all. You can't shock Joe and Betty, but you can appeal to them emotionally.

The second way people respond is through their pocketbook. Break down your statistics to what it costs Joe and Betty every day.

Humor is the third way people respond. Your issue is not humorous. Your cause isn't humorous. But humor is a great way to relay a message that you can't do straight sometimes. I brought this cartoon as a wonderful illustration of when humor can be used. It shows the mother sitting here, and she says, "I'm against abortion, sex education in the schools, and forcing adult issues on children. So what does that make me, a right wing loony?" And over in the corner is a little girl coming in with a baby in her arms, and the little girl says, "No, it makes you a grandmother." Powerful. Powerful. If you can use that, do. It walks a fine line, but it's a powerful message that you could never say straight and get by with it.

The last two things I'll tell you is to use your third-party endorsers. Joe and Betty don't want to hear from me, they don't want to hear from you. They want to hear from the people who have lived through it. A good example that I would use is a man named Nick Kalson. One year, a man in our financial

office called me and said, "Kyla, do you know who Nick Kalson is?" I replied, "I've never heard of him. Who is he?" He said, "Well, he's a farmer from here in Colorado, and I just thought it was sort of interesting that last year he brought us a check for \$200. This year he brought us a check for \$500," I asked, "What for?" He continued, "He holds a barbecue in his back yard to raise money because his nephew died in the newborn center and his brother and his wife couldn't afford to pay the bills. So a bunch of the cowboys got together and threw a barbecue and raised that money." I said, "That's terrific. That's real great. I'd like to meet him."

So I remember having to get up at 4:00 to catch Mr. Kalson at 4:30 before he got out his door because I could never reach him. Finally I did. I said, "Mr. Kalson, I'm really impressed with your fundraising and doing this on your own. I'd like to meet you and give you a tour of the hospital and see if we can't help you." He said, "I think that would be great. Can I bring my buddies in?" I said, "I wish you would."

So he and his buddies came in with their cowboy hats and boots and we walked around the hospital. He went in the newborn center and cried. As we walked around he said, "I think we'll keep doing this." I said, "Well, we're going to help you. The first thing I want is to know what radio station you listen to." He looked funny and said, "KLZ." [That's the top country station.] I said, "Well, we're going to get you together with them."

I went to KLZ and talked to the general manager. I told him what Mr. Kalson was doing. I talked to Bud Spratlin, who was one of our donors who owns Readymix Concrete. He went out and poured a big slab to dance on and he poured a great big barbecue pit. We started talking to all these people that feed into us from the country and from our community. By the time that the next barbecue rolled around the radio station jocks were out there and we had 2,000 people in Nick Kalson's back yard. We raised \$15,000 and had a ball doing it. All the farmers donated a big trailer full of fresh corn. We had the 4-H kids' calves and lambs and we barbecued them. Last year was the ninth annual Nick Kalson barbecue. Sixty-two hundred people went to the dance. He has to do it two days, Saturday and Sunday. He's raised over \$260,000. That's the strongest story I have to share with you of a third-party endorser. He is a hero. Joe and Betty would relate to Nick far more. We in the hospital would go around and we were his grunts. We'd work and peel corn. He was the one they wanted to meet. He was the one they related to. He was a great, great friend for us.

The other one is media stars, especially if you have any media stars who have children that have had trouble. We had a man named Ed Green who is very well known in the media and whose daughter was in our newborn center for three months. He's done videos, he's done interviews; he does an awful lot to promote our cause.

The last thing I will suggest to you is to never give up. It's just an incredible amount of work. I know your budgets are lean. I know your time is precious. I know how dedicated you are. I know how important these issues are to you and you're right. You are right. They are crucial. They're very important and Joe and Betty should learn about them. Just don't give up. You have to keep at Joe and Betty constantly. Remember Joe and Betty's 17,000 messages a day. Don't give up.

Look at the litter campaign. Remember the litter campaign? When I was growing up, I remember that they really educated us in the schools about don't throw trash out your window, pick up your campsites, and all of that. That was so ingrained in me during the days when my morals and values were being shaped that today my son says if I see somebody litter, I want to stop and beat them up. The litter campaign worked, finally, after years and years and years.

Look at the no-smoking campaign. You are making inroads there. I can swear to you now, when I go into major conference rooms, no one smokes anymore. No one does. If they do, they might be intimidated to go back to the end of the table. Or they'll be polite and not smoke in front of everybody else. We're making inroads into that issue. It just takes time. It takes a long time and hammering and hammering and hammering away. So don't give up.

The final thing I want to say is that through public relations you can promote your products and you can do it well. But please, stop short-changing the promotion end of it. Think about the amount of money you spend to set up a program, and how much you leave over to promote it and tell Joe and Betty. Usually nothing.

You can sit here for two days and know everything there is and educate each other, but what good is it until you have the funds and the resources to tell those people out there what you know. Stop short-changing that end of it. You can be just as smart as you want in your issue, but it's Joe and Betty who are going to make the actions. It's their behavior you're trying to alter. So I'll put a real plug into you trying to spend more time and budget public relations. I hope some of those ideas might help you. Do you have any questions?

Questions from the audience:

Q: (Coke Classic)

A: That will go down as the classic public relations mistake. All the public relations staff was fired, you know. What I hear in the industry is there was a total misinterpretation of the research that they had done. I think it was just the biggest mistake ever. People just love tradition and hang onto that sort of thing. The cost to Coke was \$32 million. They lost \$32 million on the stupidity of that campaign. So my guess is that they didn't really know what Joe and Betty really wanted.

I'm suggesting however it was worded to Joe and Betty, it wasn't clear enough. They probably solicited an answer they wanted to hear and not what they should have. They did change Coke back and now Joe and Betty are buying it.

Q: (Public handbook on agency programs)

A: Again, identify your public. Try to find out how they get their messages. I don't know about legislators in Montana. I would imagine that they're similar to legislators in Colorado. First of all, legislators do read. What they read are the sports pages and the editorials. (I left that out, by the way. In the research that we did for teenage fathers,

their number one reading is the sports pages in the local dailies. That's what they read.)

But back to legislators. First of all, they do read. That's why I'm suggesting getting to the media to get whole editorial board briefings. I don't know your papers, but you have to have an editor and you have to have assistant editors. You can go and suggest that you have a meeting with them. Set up a meeting and sit down and tell them about your issues and what it's concerning. You don't necessarily need them to write a story for you, you just need to background them. Hopefully what you might get out of it is an editorial by the paper endorsing your cause, and that is impressive to legislators.

The other thing that's impressive to legislators is that we always toured them through the hospital. We always took them to the newborn center because that was the grabber. Use emotion with them. They're human, too. We had a newsletter that went to the legislators four times during the legislative session. It was just one sheet with our major issues. That might be a good idea for you. Something like: "These are things that we think you as legislators should know about prenatal, perinatal, preschool health." And just keep hitting them, hitting them.

The other thing is to lobby. Go down there and lobby. I'll bet some of you do, don't you? Go down to the Hill and lobby? Lobbying is getting a better name now. Just get them on your side. Find the people in the legislative community that have had personal experiences with unhealthy pregnancies of their children or themselves, or whatever.

Q: (Where to target prevention education for preschoolers)

A: Immunization education for parents. Parents sometimes don't know how to tell temperature. They don't know which end of the thermometer to use.

Find out where those parents hang out, first of all. All women go to grocery stores. You might do some educational blurbs on the grocery sacks. You might do just one-piece, simple flyers that you can leave around on different topics of education. Like "Why should your child be immunized?" A lot of short educational things in very, very lay terms. You know that with your audiences. Don't talk in your parlance. Talk the way they talk and do some educational things that way. Do something through the schools, because they come in to the preschools or the nurseries or whatever. Use bumper stickers, too. You're a transportation state. Get bumper stickers on those pickup trucks. Say, "Do you want to learn more about your child? Call such and such." Those kinds of tricks.

Even home educational seminars for parents, have you done that? Go into their communities and their neighborhoods and say do you want to learn more about the health of their children? Do you know why you need to be immunized, or how to take temperatures?

Don't ever assume that the public out there knows a lot about health because they really don't. I was always shocked at the amount of mothers who had never taken a temperature before.

Q: (Day care)

A: Don't forget the working mothers, please. I'm still so irritated at my son's school who has no consideration for us working mothers at all. All of the PTA meetings are held during the day. All of his meetings and conferences are held during the day. I fought with that at Children's. They wanted 9 to 5 hours, but how many women work today? Sixty-seven percent. You're changing. The doctors would say to me, "Would you want to work on Saturdays?" I'm not in that profession. I don't have to. But I'm seeing more and more doctors that are going to have to, depending on what kind of doctoring you do. But you have to accommodate the working mothers.

Don't forget the bars because healthy young women hang out in bars. That's where they get unhealthy.

Q: (Do many public health agencies hire PR people?)

A: No. I wish they did. I see they need it, but I think it's a matter of education. It's a matter of realizing that you can keep educating yourselves. You paid for this conference. It's a matter of education. If you're going to educate yourselves all the time, fine, but you have to spend some money to get out there, too, and it costs. It doesn't cost a lot. The most costly part of imaging is advertising, but you can do publicity. I never advertised at Children's Hospital and I had more publicity around that hospital for eight years. Now they're starting to advertise, and it's good.

Public relations is a real clean function in the fact that you have to set objectives that are measurable. When you've done a publicity or public relations program, you should be able to show results and measure it and tie into the bottom line. It's hard to do that with public attitudes and opinions, but it's crucial because everybody's concerned about the bottom line. But if you don't tell the people out there, you've got another best-kept secret. You have to promote what you do.

IT'S ALL IN YOUR HEAD

Robert W. Lind, Ph.D.
Human Development Specialist
Cooperative Extension Service
Montana State University

Throughout the conference so far you have been hearing medical facts and theories related to disease prevention and health promotion, and no doubt that will be the case for the remainder of the conference, for the most part. Now, I was not a Rhodes scholar, but I am at least smart enough not to make light of that sort of thing. There are indeed ways to promote better health through positive health practices, and there are indeed ways we can control or limit the spread of infections and contagious illnesses. And, of course, we ought to learn what we can about such things and practice them.

However, the reason that I am on the program, as I understand it, is to remind you that there is another facet of health to be considered. Health promotion and disease prevention through medicine and other medical types of approaches is not the whole of the truth of life. There is also the human, the psychological-emotional aspect to health, which asks us to recognize that good health is not just a matter of having healthy kidneys and blood that has all the right stuff, and none of the wrong stuff in it. The power of one's mind is such that people can die when there is nothing wrong with them, or they can live when they have several dreadful things wrong with them. It is possible for people's minds and attitudes to be so badly poisoned from their upbringing that they are rendered incapable of effective functioning, and their chances for success and happiness in life are very seriously diminished.

This being a day in which we celebrate children, it seemed fitting that I share with you a couple of notes kids wrote to their moms on Mother's Day. Like this: "Dear Mom, I got you a turtle for Mother's Day. I hope you like it better than the snake I got you last year." "Dear Mother, I hope you like the flowers I got you for Mother's Day. I picked them myself when Mr. Smith wasn't looking." "Dear Mom, Arthur and I promise not to fight all day for Mother's Day. P.S. Arthur doesn't know yet." "Dear Mother, Have a happy Mother's Day. Here are two aspirins."

As we teach children that they must misbehave in order to get our full attention, we also teach them the value of illness by saving our most generous solicitude for the sick. You never get so much tender, loving care lavished upon you as when you are ill, in the average family. You learn that it pays in certain respects to be sick. You learn that if you feel the need of some extra love and consideration from others, you can get it if you will come down with something.

We learn that we can use illness as a way out of some of the really unpleasant, painful and frightening circumstances of life. If you get sick, you don't have to go and face the music. Or, if you do go when you are feeling poorly, you have a perfect excuse for a low level of performance. You can always say, "Of course I flunked the test! I was sick as a dog that day, but I forced myself to go anyway."

We may finally become so good at this that we can get our illnesses right on cue, almost the the minute when we need them. I knew a minister who hated doing the monthly parish newsletter, and he would come down with a roaring head cold on the very day the job was supposed to get done each month. It didn't stop him having to do the newsletter, but it gave him an additional source of pain and suffering to go along with the hated task, and they made a great pair, the plague and the paper.

Good health, some say, is all in your head. One of the persons whom I heard say that not long ago is a friend of mine who happens to be a doctor of medicine. He said, "More than three-fourths of those who fill my waiting room day after day and will allow me in a few more years to retire in luxury have nothing wrong with them except illnesses they have chosen for themselves, and which none can ever cure except they themselves."

People really are funny in a lot of the concepts they have concerning health. Just a few days ago on television I saw a report of some people rising up in wrath against the blasphemous Contac ad done by Steve Landesberg. He suggests that Contac is better than chicken soup for curing colds. These people believe mightily in the real curative powers of chicken soup. I myself suspect that chicken soup is better than Contac and other such things -- probably doing nothing is better than Contac -- lots better, but I seriously doubt that chicken soup has any real curative powers. There are old wives' tales about health practices which are funny to recite, having to do with poultices, acidity bags, garlic necklaces, and so on and on. The garlic thing may very well work, in that it keeps others from getting up close enough to you to transmit their germs.

I just discovered there are also some old husbands' tales. Old wives' tales refer mostly to folk medicine. Old husbands' tales refer mostly to home maintenance. Here are a select few:

A kick in the side or a whack on the head will make any mechanical appliance run.

An article of clothing which bears prominent stains, even more prominent odor, and is shabby and threadbare will bring incredibly good luck to its wearer.

Mowing the lawn earlier than 2:00 pm is likely to disturb the neighbors.

The repairman will always overcharge a woman.

Shoveling snow puts strain on the heart; playing golf is good exercise.

Any sound heard in the house after midnight is the neighbor's cat, the wind or the plumbing, and does not require investigation.

In this conference, the focus of concern is the young child, and I think that is a wonderful area of focus. Young children, during their most formative years, are being shaped, molded and set for life every day by the attitudes, opinions and practices of their elders. In the Old Testament there is line which says "the sins of the fathers are visited upon the children unto the third and fourth generation." I am not sure about the sins, but I am very sure about the neuroses, the phobias, the attitudes, and the psychological mind-set of people being passed on to the children.

You've all seen the popular bumper sticker which says "Insanity is hereditary -- you get it from your children." While it is true that children do a certain amount of driving their parents crazy, it works the other way far more often: parents drive their children crazy. The attitudes, the values, the hopes, dreams and fears of the parents are visited upon their children unto the third and fourth generation.

At the table in my house, I remember the Sunday we were eating dinner with my daughter and her husband and child. My granddaughter, Nancy, was enjoying her dinner and eating her baked squash with relish, until she observed that when the plate came around to her father, he wouldn't take any, saying how he disliked squash. Nancy thereupon refused to eat another bit of squash. She had erroneously thought she liked it; from her father she learned what her attitude toward squash really should be.

Children, unaided by parents, will often form more healthy attitudes. In a classroom of third-graders where there was only one non-white child, a classmate described that child as "the one in the blue shirt" and not as the one with a different color of skin.

When I was first going to college, more than 30 years ago, the current wisdom was that the first six years of life were the most formative ones. About ten years ago Dr. Burton White of Harvard, one of the current stars in child development, wrote a book called, "The First Three Years of Life," in which he make the suggestion that those are the most important years for the formation of attitudes. There are those who say that while of course the first three years and the first six years are very important, they are nowhere near as important as the first three to six months of life. And more than one researcher has suggested that there are even some significant prenatal influences on the child in the womb.

What it all boils down to is that while we cannot be certain whether it is the first days or months or the first three to six years, we do know for a certainty that by the time a child starts school, he has already learned most of what he will ever know in terms of his life attitudes, his mind-set toward the world and the people in it, his attitudes about life and health and work and sex and learning, and all the rest. Again in the Old Testament we remember the line which says, "Train up a child in the way he should go, and when he is old he will not depart from it." And the line, "As the twig is bent, so the tree is inclined." They do seem to have a ring of truth.

I'm going to be sharing with you some attitudes, practices and values which we can use and instill within our families, which will have the long-term effect of driving our children sane, not crazy. This lays a

heavy trip on parents, and parents today have loved to take refuge in the thought that children are their own people, and that parents are not really responsible for what their children do.

I should soften this a bit, perhaps, so that it will be clearly understood that parents should not be held accountable at all times for all things a child of theirs may do. As they get older, children do act on their own and the parents are not always in all ways responsible for what their kids do. Yet, I also know it to be true that although my own father has been dead now for 30 years, his attitudes and values continue to this day to guide me and instruct me, and they are the values which are the basic guides of my 4 children and my 8 grandchildren. The values and attitudes of my father are this very moment being visited upon the children unto the third generation.

You've often heard someone referred to as "the spittin' image" of his or her mother or father. It was interesting to me recently to see an explanation of that strange phrase. It seems that when a child was observed to look and to behave a great deal like one of the parents, the child was said to be "the spirit and image" of the parent. In colloquial use, the term "spirit" was more often pronounced like "spit," and that is how we came to use the term "spittin' image." It is very, very likely that your children are your spirit and image, because you have been for them their major role model. In figuring out what adults are, what a mother or father is, what mothers or fathers do, how husbands and wives behave toward each other and toward their children and family and neighbors, your children have their eyes on you.

All of this is the reason why I have always felt that if we are deeply concerned about children, we must be deeply committed to programs that serve the parent and grandparent generations. It is the parents and grandparents, the significant adults in the child's life, who create, educate, civilize and instruct the child. I cannot hope to teach your child, in a chance encounter, or even having him or her all day in a classroom, the attitudes and values necessary for successful living. You, in your homes, must do it. You do do it, you always have and always will. Just as the Jukes and Kallikaks succeeded always in teaching their children how to excell in criminal activity and stupidity, the best of our families today teach their children how to succeed in life through having healthy emotions, healthy psychological frames of mind, good attitudes toward themselves and others, and positive feelings about this world and life in general.

Kids do say the darndest things, as Art Linkletter noted in his book long ago -- like the 8-year old who only a week ago saved another child's life who was choking on some pennies he had swallowed by using what he called "the Heimlich remover." Of course! That's exactly what it is. That's a much better name than the Heimlich maneuver. Little Sally, whose nursery teacher was named Mrs. Murphy, learned to repeat the 23rd Psalm, but near the end she said, "Surely good Mrs. Murphy will follow me all the days of my life..." Gives you quite a picture! You who are medically-oriented people will be able to appreciate these little excerpts from essays children wrote to describe human anatomy, a few of which are as follows:

The fingers are used to scratch with and to write checks. Otherwise, you would itch and have to pay cash.

The mouth is the biggest hole in your head and the only one you can spit out of.

The head itself sits on the very top of the body on the neck which is the only place you can easily hang a soap-on-a-rope when you take a shower.

Hair is on the very top except for some men whose head grows up through it. It is all colors except for older women. In that case, it will either be gray or blue.

The chest is right above the hips and has four sides except for girls which have six.

The role, task, duty and privilege of adults is to provide guidance for children. To a very large extent our children are going to be what we make of them. Their values will not likely be better than our own, nor very different from our own. Their feelings about themselves and others will be very much like our own, for as it is said, water does not normally rise higher than its source.

I want to share with you now ten ideas which I think are lifesaving ideas, critically important for successful living. These ideas we can and must teach to our children daily from the first moment of their life. If these ten lessons are learned well, you will assuredly drive your children sane, instead of allowing them to drive you crazy. There is not an age at which it is too late to begin, and certainly no age at which it is too soon to begin teaching these critical values for successful living.

Not only are these concepts for the development of the young; they are also, for the most part, ideas which may prove to be lifesaving in terms of your other relationships, such as your marriage and your career.

1. Love Abundantly

Nothing can take the place of love in a child's life (or an adult's!) The nicest home, the fanciest toys, the best-trained babysitter cannot replace parental love. From the moment of birth and every moment thereafter, the child must be secure in the knowledge that those who care for him truly care about him. You and I know what a feeling of strength and support it gives us to know we are loved. It is the same for children.

When my first grandson was about three, he and his family came to spend a weekend with us. I saw him standing in a doorway with a huge grin and asked him what he was so pleased about. He replied, "I am so happy to be here, because everybody likes me." Armed with such confidence, we can tackle anything. By contrast, one of my sisters has a grandson whose father doesn't care for the boy. One day, picking strawberries with my sister, he found a particularly large and red berry. Holding it up to her, he said, "Grandma, if I give this one to my daddy, do you think he would love me?" Armed with that sure knowledge of being

unloved, everything is a problem.

Parental love needs to be recognized by the children as being unconditional. To have our love he or she doesn't always have to stay clean, behave perfectly, get only A's, and color within the lines. On occasion, of course, parents will experience anger, frustration, and disappointment, and they have a right to express it. But love bears up through all manner of circumstances.

About a week before Christmas of 1978 (December 18), this ad appeared in the Bozeman Daily Chronicle for several consecutive days. Considering the message, I thought it was very appropriate for the box to be edged in black:

MICHAEL OWEN CLONINGER
IS NOT MY SON.
I DISOWNED HIM YEARS AGO.
GRR CLONINGER

Obviously, there had been some very bad trouble between them, enough for the father to feel justified in making that drastic disclaimer. But you can't stop being a parent by placing an ad in the paper. Parenthood is a lifetime commitment that cannot be sidestepped. Such a thing as this could never have happened between a parent and child who had a bond of love, no matter what kind of misbehavior may have occurred.

Parents must learn to become comfortable about expressing love to their children, so the child can never doubt its presence. It's not possible to hold and hug and pat and kiss a child too much. All that garbage about spoiling a child -- forget it. Love doesn't spoil -- it lasts forever. Besides the physical contact, speak of love also. Actually say, "I love you." And say other nice, loving things, too. Express your appreciation for children's good behavior, for little things they do to help.

To love abundantly doesn't mean you let the child run wild and always have his own way. You have a perfect right to have your standards and to require compliance. Because you do love the child, you sometimes have to say no. You can spoil a child by not asking him to meet any kind of standards of behavior, but you can't spoil him with love.

When you correct a child, if you do so with a hug or a kiss, it enables him to separate himself from his behavior, and he gets the message, "Mommy loves me, but she doesn't like what I did." The innate sociality of humans leads us to want to please those who love us, and we can be confident the child will try to meet our expectations.

Every child has the divine right to be born to people who will love him. An abundance of love can make up for lack in many areas. The family may not be wealthy, but if love is there, that's the one thing that matters most, and it doesn't cost a cent. Everyone, every family, can afford all they need of it.

2. Discipline Constructively

Unfortunately, too many of us hear the word "discipline" and think

"spank" or "punish." Discipline really means the teaching of a set of behaviors or standards of behavior. We say a child is well-disciplined if he seems to behave properly in a variety of situations: home, school, church, shopping, playground.

Many years ago people believed that children were evil by nature, and that their wills to be unruly and disobedient had to be broken, in much the same manner that slaveholders had to break the spirit of the slaves to make them obedient and utterly dependent on "Massa." I've known of a few parents who treated their kids that way. It's not a pretty thing to see. Such parents have to see themselves as the Gestapo chief, and the family becomes an insane game of cops versus criminals.

We now know children are not basically evil. They are basically wonderful, full of life and love and excitement. They have no way of knowing what the rules are, so we must give them instruction and display a clear expectation that they will abide by the rules. We must trust in their basic goodness and their social nature.

Rules should be as few as possible and they should be clearly stated. There should be some reason to the rules, most of the time. "When you're finished eating, take your plate, cup, and silverware to the kitchen, so it will help us in doing the dishes."

Parents have a perfect right to have certain rules and requirements, and children don't resent them in the least, if they are fair and reasonable. You have the right to make decisions. Children with high self-concept have parents who have standards and demand compliance. The parents are firm, but fair and loving.

Consistency is an important factor. The child needs to have the security of knowing where the boundaries are. He can say, "It's okay if I do this, but Mom won't let me do that." It drives a child wild if one day he is allowed to get into the pots and pans, the next day he gets spanked for it, and later on it's okay again. He can't figure out where he stands then.

Nobody can be entirely consistent, but it's a goal worth striving for. Have as few rules as possible and enforce them as consistently as possible and you won't have much trouble.

Don't talk too much. Words aren't effective. The child learns not to respond until you get to the "this time I really mean it" stage. Say what you mean, mean what you say. Be careful about making threats. But when you threaten, don't fail to follow through. The child must know that when you speak, you mean business.

The whole aim of discipline is to make the rules of behavior a matter of second nature so the child will behave properly when he is out of our sight. Children need to learn a sense of independence and this comes from being able to make some of their own decisions. Everyone, in order to feel okay about himself, needs to have some feeling of being at least somewhat in control of his life. That's why it's important not to have too many rules. Some room must be left for initiative. Children love to make choices. Mom may insist "you have to have some fruit with your breakfast." But the child can decide between having grapefruit, orange

juice, or a banana.

At the end of the process of discipline we envision our child as a person who is able to function properly on his own power. He can do this only if he get the proper training and enough experience in making choices that affect his life.

3. Spend Time Together

One of the most frequent laments of parents whose kids are grown is "How I wish I had made more time in my life for them when they were little!" Time is so fleeting and so precious. Those moments come, and then are gone forever. Play with the children. Talk with them. Teach them things that you do so they can help and participate. Plan lots of family activities. They provide wonderful memories and happy times for years. We all get a good laugh remembering the good times. Our kids are all grown, and we have lots of good memories. But if I could have done it over, somehow I would manage to work in ten times as many as we had.

At least once a week, depending on how many kids there are, each parent should have a special time alone with each child. Dad and Cindy can go for a walk and see how many different kinds of birds or flowers they see. Dad and David can go fishing. Mom and Cindy can work on knitting. Everyone can go on a picnic. There is no end to what can be done. But there is nothing like getting to know your kids as people. They are amazingly complete human beings, you discover. They have some good ideas, some interesting questions, some fears and hopes and dreams that they'd love to share with you, if you had the time.

There is nothing you have to do that is as important as being present to your kids. About 10 years or more too late I made the realization how important this was. Until then I was like everybody else, so busy earning a living that I didn't have time to live. But one day I resolved, and have never since failed, that any time my kids needed or wanted me, I'd drop anything I was doing to be with them when they asked for me.

My only regret is that I didn't have the sense to make that commitment on the day our first child was born. This is perhaps more important for dads than moms, because moms are with the kids much of the time anyway. But even moms can be so busy working and watching over the kids that they really don't spend time with them on a person-to-person basis. Taking care of them and really being with them in person can be two very different things.

Spending real quality time with your kids will enrich them -- and you -- immeasurably. And, tomorrow, when they are grown, you'll have a wonderful store of memories and few regrets. In Fiddler on the Roof, the song "Sunrise, Sunset" says it well:

Is this the little girl I carried? Is this the little boy at play?

I don't remember growing older. When did they?

How did she grow to be so pretty? How did he grow to be so tall?

Wasn't it yesterday that they were small?

4. Tend to Personal and Marital Needs

It's been said the greatest advantage a child can be given is the example of loving parents. You can't fill glasses from an empty pitcher. You can't give what you don't have. To be able to give love and security to a child, you must possess them. Treat yourself well. You are a person and you have a right to life as well as anyone else. Some little fraction of every day should be yours alone. And some fraction should be for the parents alone. A household in which love is expressed between the parents is a blessing to the child. It provides for the child a model for his expressing of affection. The expression of tenderness and love between all family members starts with the open expression of affection by the parents.

Grown-up kids often comment on the expression of affection they saw at home, and realize it was an advantage to them. Just as it makes children unhappy and fearful to be living in a situation of marital conflict, it makes them happy and secure to live in a situation of love and harmony.

5. Teach Right from Wrong

The values of the Smith family will probably not be identical to the values of the Jones family, but parents do need to teach their values to their children. There is no way you can prevent the children's acquiring of your values, really. They will do as you do, not as you say. Such things as honesty, religion, attitudes toward education, moral values, respect for others, and responsibility are important. Society has entrusted the family with the task of raising persons who will uphold the society's standards and customs. But you can't teach any of them as a lecture course. Your children will catch your values from your daily practice. If you say, "Be honest," but then do something dishonest, they learn your acts, not your words. The Golden Rule is the best advice for living, but the only way it can be taught is by example.

Edgar A. Guest wrote "Sermons We See," and in one stanza are these words:

I soon can learn to do it if you'll let me see it done;
I can watch your hands in action, but your tongue too fast
 may run.
And the lecture you deliver may be very wise and true,
But I'd rather get my lessons by observing what you do;
For I might misunderstand you and the high advice you give,
But there's no misunderstanding how you act and how you live.

6. Develop Mutual Respect

Crucial to the entire parent-child relationship, mutual respect is the child's sure foundation for growth and development. The child and parent are in a special relationship, but both are persons, separate, unique, and wonderful in their own right. Each person is a unique event in human history. The child's sanctity as a person must not be violated. He has feeling, fears, wants and wishes that are just as real to him as yours are to you. He feels just as you do toward people who treat you

unfairly, who ridicule you, who insult you, who mistreat you. He likes those who help him feel good about himself, who enhance his self-respect, just as you do. He responds just as you do to encouragement, appreciation and understanding. Don't let your child mistreat you as a person and don't mistreat your child as a person. Respect his dignity as an individual, and he will respect you.

7. Really Listen

You wouldn't believe how many kids get all the way to college without ever having talked to an adult. They say their parents told them what to do, when to do it, what not to do, and all of that, but they never had a conversation with their parents. Their parents never had time to find out what was happening in their kids' lives. What's happening at school? Who are your friends? What do you like to do best in school? Out of school? What do you think about going to college? Rather than considering you nosey, most kids would be delighted to think "my parents care about what's happening in my life."

Help them to express their anger, frustrations, fears, and needs. Help them to talk about what makes them happy and what makes them blue. If they learn you can be trusted to be non-judgmental, they'll never fail to come to you. Don't cram down their throat your answer to their problems, but help them to search for their own answers. I could say, "If it were me, I don't think I'd do it that way." Or "I remember when I once faced a similar thing, I chose to do this about it, and it seemed to work out OK." You can share your feelings and experiences and they can use what they want of it. Incidentally, they will almost always make the choice for themselves that you would have made for them! After all, they have been in your home, absorbing your values, for a lot of years.

8. Offer Guidance

Learn how to give suggestions and advice without making an hour-long sermon. State your thoughts in a few sentences. Convey the idea that you expect the child to think about his problems and have some of his own ideas for solutions. The parent mustn't accept the role of "I'm the one who solves all your problems for you." Start young. Don't solve all problems for your creeping baby. Let him find his own way out from under the chair. If he's really stuck, give him just enough help to get him started and then back off. He will feel better about himself.

Let children know your door is always open to talk about anything. And don't be afraid to say what you think or what you feel. But don't tell the child what he should think, what he should feel. Forbidden fruit is the most tempting. You can drive a child to do some things by saying, "I absolutely forbid you to do that." So go easy on the ultimatums and the absolutes.

Your child wants the benefit of your experiences and wisdom. He knows you've been around the track a couple of times, and he probably considers you good and wise, so he is predisposed to accept ideas from you. You must say, honestly, what you think and what you feel, in confidence that your child will almost always make the right choice.

9. Foster Autonomy

Perhaps the most difficult part of parenting is letting go. We must teach them to walk and then to walk away. The guidance style we've been discussing is an example of giving the child greater self-governance or autonomy. In one sense, this is a matter of weaning the parent away from the child. The child will eventually grow up and leave. The parent will have to let go. It's easier to let go inch by inch than all at once. So the progressively greater autonomy of the child is a help for the parent. But it's mostly a help for the child. A great deal of personal confidence and self-esteem is generated by being able to make some independent actions.

Parents sometimes don't allow for any decision-making on the part of the child. Every move from rising to sleeping is choreographed by the parents. A large part of what most parents say to their kids is in the forms of commands: Get up! Go to bed! Do your homework! Take out the garbage! Clean up your room! If one has no freedom to make choices, he comes to feel like a puppet, capable of moving only when someone pulls the strings. It has been found that, for people of any age, their sense of satisfaction with life is directly related to having the feeling of being at least somewhat in control of their own life. You know that's true for yourself. You are free to select the clothes you will wear, to make choices about what to eat, to decide what you will do today, and so on. You have a feeling of possessing your own life. Your child should also have such feelings.

You cannot allow him to make major policy decisions, such as whether to dress or be naked. But you can let him choose what to wear.

One of the most important things we teach when we allow children to make decisions is the matter or responsibility. Children see adults making decisions, so they want to do it, too. But we must teach them that every choice has some consequences. The one who makes a choice is also choosing the consequences. It is absolutely imperative that the child learn to accept the consequences of his acts.

Parents have a poor record in this department. They can't bear the thought of their child suffering even a little, so they intervene, and the whole impact is lost. The child learns, "If I make a bad decision and wind up in the soup, Mom and Dad will bail me out. I won't have to pay for my mistakes." What the child learns then is to be irresponsible.

If Mary chooses to ignore your call to come and eat lunch, she is choosing to wait until dinnertime to eat, unless you are running a quick-food restaurant. Her hunger is her business, and her problem, freely chosen. If she misses lunch, that doesn't make you hungry. It is her choice, so let it be. If she doesn't like being hungry, she will come tomorrow when lunch is called. No preaching or scolding from you is required. It was her choice, so it's her problem. People can go many days without food. Mary won't perish before 6:00 pm if she misses lunch. You can even be understanding: "I know how you feel, Mary. I'm sorry you missed lunch. We had a nice lunch today, too." This is one of the most important lessons you can teach. Allow the child to make decisions, starting at an early age. But also allow the child to live with the consequences of his choices. Very, very rarely are the consequences so

extreme that you really have to intervene. Incidentally, scolding and spanking ruin the entire effect. Let the consequences do the teaching.

10. Be Realistic

Your child is only a child, and children have a right to be childish. Children lack a lot of wisdom and experience, and we shouldn't expect them to measure up to unreasonable standards. Be realistic with yourself as a parent, too. We all make dumb mistakes. We lack a lot of wisdom and experiences as parents, and we shouldn't set unreasonable standards for ourselves. Basketball teams have the objective of putting the ball in the basket but realistically they know that any team that can consistently score on 50% or more of its shots is doing extremely well.

We parents are always trying to do the right thing, but if we score on less than 100% of our efforts, we are probably still doing just fine.

One form of unrealistic expectations of children has to do with expecting too much. The first child who is physically larger also gets it. If Nancy is only 5, but equal in size to most 7-year olds, we often expect her to act her size, not her age. That's a bad mistake to make, and we should guard against it.

But a mistake I see parents make very often is that of not expecting enough of their child. Parents tend to hold the image of their child as a baby, and so they have low expectations. In school we find teachers showing parents samples of work, and parents say, "No, Johnny couldn't have done that! My Johnny? He's not capable of that type of work." Chances are good that your child is more capable than you think. He is possible able to achieve more, to accomplish more, to accept more responsibility than you realize. Give your children opportunities to test their limits and don't hold them down.

Don't require the child to be anything more than what he is. Don't have unrealistically high expectations. But don't err by having too low expectations, either. Let him test his limits and do all he can.

I have a cousin who is mentally retarded. All his life he was quite totally helpless, until his parents died, just a few months apart. Since that day he has become an utterly new person. His speech improved 1000%, he can function in society, he works regularly and can go shopping alone. For more than 30 years he was held helpless by their low expectations. It was a needless burden to them, and an injustice to him. What a pity that they had to die before he could live!

I believe that all of this adds up to a sane and rational approach to child-rearing. By following these guidelines neither the parents nor the children should be driven crazy by the process of parenting. Rather, both parties should be pushed by this type of process toward a more stable and meaningful life.

The work that parents do has a profound effect not only on the lives of their children, but unto their grandchildren and their children.

Your basic starting position as a parent is pretty much to do as you were done to. You parent as you were parented. For example, virtually

all abusive parents were abused children, so they parent as they were parented. Therefore, if you now acquire some really healthy and wholesome attitudes and impart those to your children, your great-great-great grandchildren 150 years from now will yet be beneficiaries of your labors. Take the best of what you received from your parents. Add to that the best you can learn right now, and pass both of these on to your children. There is nothing anyone can do to create a better tomorrow that is a more significant contribution than that.

Erma Bombeck is a great humorist, but she has also written a few things that are wonderfully wise, sensitive and touching. I will close by sharing with you one of her unfunny pieces:

Someone asked me the other day if I had my life to live over would I change anything.

My answer was no, but then I thought about it and changed my mind.

If I had my life to live over again I would have waxed less and listened more.

Instead of wishing away nine months of pregnancy and complaining about the shadow over my feet, I'd have cherished every minute of it and realized that the wonderment growing inside me was to be my only chance in life to assist God in a miracle.

I would never have insisted the car windows be rolled up on a summer day because my hair had just been teased and sprayed.

I would have invited friends over to dinner even if the carpet was stained and the sofa faded.

I would have eaten popcorn in the "good" living room and worried less about the dirt when you lit the fireplace.

I would have taken the time to listen to my grandfather ramble about his youth.

I would have burnt the pink candle sculptured like a rose before it melted while being stored.

I would have sat cross-legged on the lawn with my children and never worried about grass stains.

I would have cried and laughed less while watching television...and more while watching real life.

I would have shared more of the responsibility carried by my husband which I took for granted.

I would have eaten less cottage cheese and more ice cream.

I would have gone to bed when I was sick instead of pretending the earth would go into a holding pattern if I weren't there for a day.

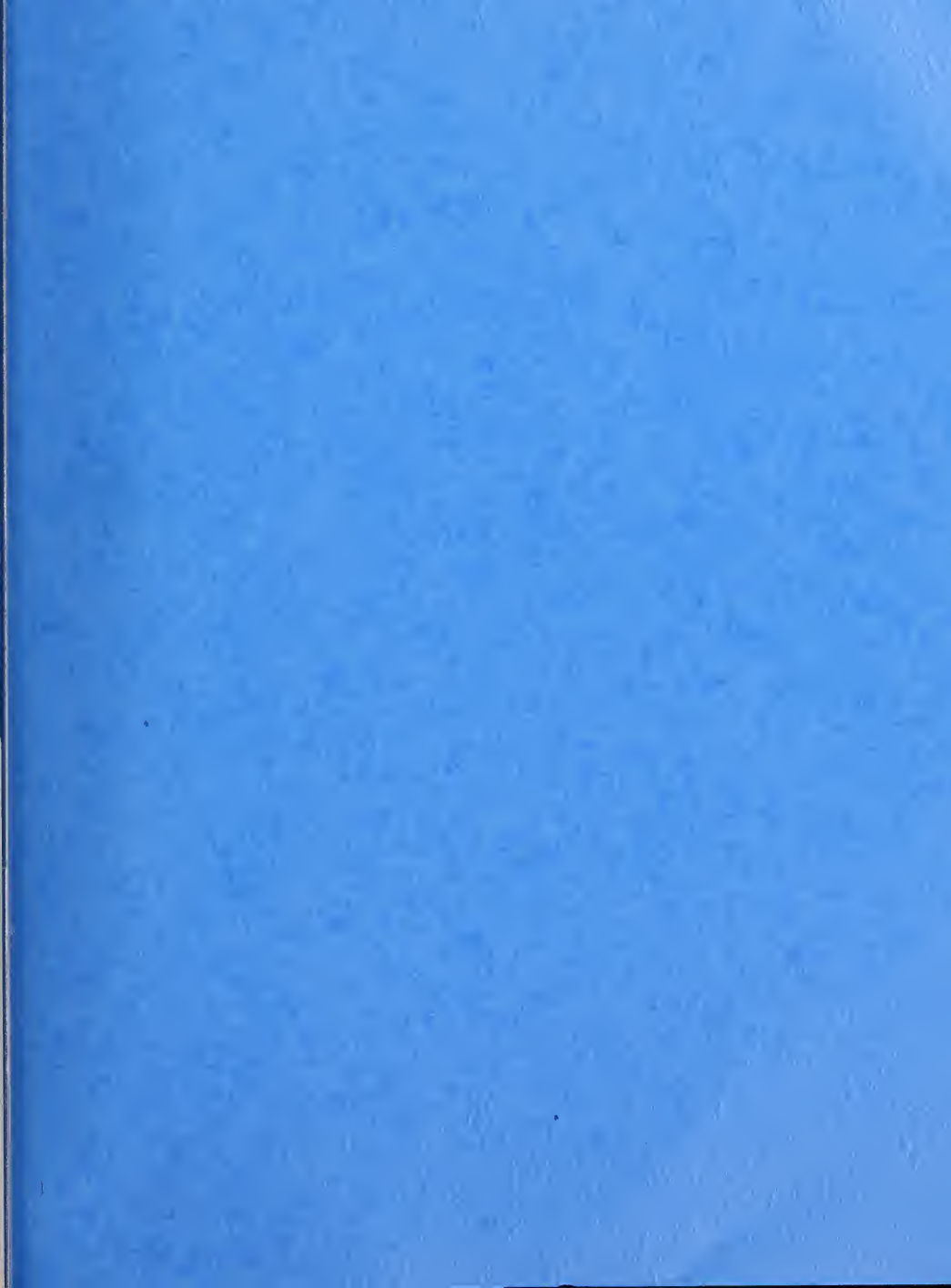
I would never have bought ANYTHING just because it was practical,

wouldn't show soil, and was guaranteed to last a lifetime.

When my child kissed me impetuously, I would never have said, "Later. Now, go get washed up for dinner."

There would have been more I love yous...more I'm sorrys...more I'm listenings...but mostly, given another shot at life, I would seize every minute of it...look at it and really see it...try it on...live it...exhaust it...and never give that minute back until there was nothing left of it...

Thanks for being here, and thanks for what you do to benefit all of us. May you all be driven every day toward greater sanity, and help others to grow ever more sane in the living of their days. Thank you all.



500 copies of this public document were published at an estimated cost of \$3.00 per copy, for a total cost of \$1,500.00, which includes \$1,500.00 for printing and \$.00 for distribution.